Nottingham University Hospitals NHS Trust

Inspection report

Trust Headquarters
City Hospital Campus, Hucknall Road
Nottingham
NG5 1PB
Tel: 01159691169
www.nuh.nhs.uk

Date of inspection visit: 21,22,23, 24 ,29 June, 14 July & 26,27 28 July
Date of publication: 15/09/2021

Ratings

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

Nottingham University Hospitals NHS Trust is one of the UK's largest acute teaching trust's, established on 1 April 2006 following the merger of Nottingham City Hospital and the Queen's Medical Centre.

The trust is based in the city of Nottingham and provides services to over 2.5 million residents of Nottingham and its surrounding communities. The trust also provides specialist services for a further 3-4 million people from across the region.

The trust is one of the largest employers in the region, with around 16,700 staff working at the Queens Medical Centre (QMC), Nottingham City Hospital and Ropewalk House. The QMC is where the Emergency Department (ED), Major Trauma Centre, hyper acute stroke unit, Nottingham Treatment Centre and the Nottingham Children's Hospital are based. It is also home to the University of Nottingham's School of Nursing and Medical School. Nottingham City Hospital is where the cancer centre and heart centre are based. Ropewalk House is where the trust provides a range of outpatient services, including hearing services

The trust has 90 wards, with around 1,700 beds and an annual budget of almost one billion pounds.

Between 21 June 2021 and 28 July 2021, we inspected two core services provided by the trust across two locations. We carried out an unannounced inspection of surgical services at Nottingham City Hospital and the Queen's Medical Centre. We carried out an unannounced [focused] inspection of urgent and emergency care at the Queen's Medical Centre and we also inspected the well-led key question for the trust overall.

We carried out this inspection of services provided by this trust as part of our continual checks on the safety and quality of healthcare services.

At our last inspection we rated the trust overall as good.

Our findings

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

On 21, 22, 23, 24 June 2021 and 14 July 2021 we inspected two core services provided by the trust across two locations. We inspected Urgent and Emergency Services and Surgery at the Queen's Medical Centre. At our last inspection, Urgent and Emergency Services were rated as requires improvement. Although Surgery at the Queen's Medical Centre was rated good overall at our last inspection, we inspected this service because we had concerns.

At Nottingham City Hospital we inspected Surgery; this was rated as good at our last inspection. We inspected this service because we had concerns.

We did not inspect Maternity services previously rated inadequate because the service had not had time to make the improvements necessary to meet legal requirements as set out in the action plan the trust sent us after the last inspection. We are monitoring the progress of improvements to Maternity services and will re-inspect them as appropriate.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. Our findings are in the section headed 'is this organisation well-led'. We inspected the well-led key question between 26 and 28 July 2021. A financial governance review was also carried out at the same time as the well-led inspection, this was undertaken by NHS England and Improvement (NHSEI). There was not a separate 'Use of Resources' assessment in advance of this inspection.

Following our well led inspection we served a Warning Notice under Section 29A of the Health and Social Care Act 2008. This warning notice served to notify the trust that the Care Quality Commission had formed the view that the quality of health care provided by Nottingham University Hospitals NHS Trust in relation to leadership, risk, governance and culture required significant improvement.

Our rating of the trust 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 outstanding.
- We rated one of the trust's services as requires improvement and two of the trust's services as good. In rating the trust, we took into account the current ratings of services not inspected this time.
- Not all services had enough nursing and 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.
- There was a backlog of patient safety incidents for services which had not had any investigation and therefore the risk presented was unknown.
- When patients were identified as lacking in capacity, staff did not always complete the required assessment and put measures in place to meet their needs.
- Mandatory training compliance had been impacted by the on-going pandemic, with some training compliance levels recorded well below the trusts own target.
- Patient records were not always securely stored.
- People could not always access the service when they needed it and therefore did not receive the right care promptly. Waiting times to admit, treat and discharge patients were not in line with national standards.

Our findings

However

- Services controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- 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.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

How we carried out the inspection

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

Areas for improvement

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 three legal requirements. This action related to two services.

Trust wide

- The trust must ensure that the disconnect between the board and the wider organisation is addressed. (Regulation 17: Good governance)
- The trust must ensure that there is collective leadership at board level. (Regulation 17: Good governance)
- The trust must ensure that measurable action is taken to address bullying across the organisation. (Regulation 17: Good governance)

Our findings

- The trust must ensure that all staff, including those with particular protected characteristics under the Equality Act, are treated equitably. (Regulation 17: Good governance)
- The trust must ensure that there are effective structures, processes and systems of accountability to support the delivery of the strategy. (Regulation 17: Good governance)
- The trust must ensure that all levels of governance and management function effectively and interact with each other appropriately. (Regulation 17: Good governance)
- The trust must ensure that safety and safeguarding incidents and events when things go wrong are reviewed and investigated and lessons learned and themes are identified. (Regulation 17: Good governance)
- The trust must ensure that there are robust arrangements for identifying, recording and managing risks, issues and mitigating actions. (Regulation 17: Good governance)
- The trust must ensure that there are comprehensive assurance systems, and performance issues are escalated appropriately through clear structures and processes. (Regulation 17: Good governance)

Queen's Medical Centre

Urgent and emergency services

- The trust must ensure patients are initially assessed and care prioritised in a timely way. (Regulation 12: Safe care and treatment)
- The trust must ensure there are sufficiently competent staff employed and deployed to meet the needs of patients. (Regulation 12: Safe care and treatment)
- The trust must ensure patients who require admission are transferred without unnecessary delay. (Regulation 12: Safe care and treatment)
- The trust must ensure risks are considered and sufficiently mitigated against, with appropriate oversight from the trust board or delegated sub-committee of the trust board. (Regulation 17: Good governance)

Surgery

- The trust must ensure all patients receive a mental capacity assessment when concerns about a patient's capacity to consent to care and treatment is identified. (Regulation 9: Person centred care)

Action the trust SHOULD take to improve:

Trust wide

- The trust should ensure that disclosure and barring service (DBS) checks are carried out on an individual before they start employment or, a DBS risk assessment in place to assist in assessing and recording the risks of allowing this individual to work at this trust. (Regulation 19: Fit and proper persons employed)
- The trust should consider a purposeful board development programme to strengthen unitary board working and the trust accountability and performance management framework.

Nottingham City Hospital

Surgery

Our findings

- The trust should ensure that incidents are investigated in a timely fashion. (Regulation 12: Safe care and treatment)
- The trust should ensure that when medicine storage concerns are raised they are addressed. (Regulation 12: Safe care and treatment)
- The trust should ensure that measures are in place to keep patient records secure. (Regulation 12: Safe care and treatment)
- The trust should ensure that all patients receive a mental capacity assessment when concerns about a patient's capacity to consent to care and treatment is identified. (Regulation 9: Person-centred care)
- The trust should consider how they intend to meet the needs of individual patients with a hearing impairment due to current challenges associated with the pandemic
- The trust should consider how older risks on the divisional risk register are managed

Queen's Medical Centre

Urgent and emergency services

- The trust should ensure that all staff receive mandatory training in accordance with national and trust requirements. (Regulation 12: Safe care and treatment)

Surgery

- The trust should ensure that measures are in place to keep patient records secure. (Regulation 12: Safe care and treatment)
- The trust should ensure measures are put in place to manage incidents in a timely manner and address the current backlog. (Regulation 12: Safe care and treatment)
- The trust should ensure they continue with their recovery plan for mandatory training to ensure compliance levels are met in the identified timeframe. (Regulation 18: Staffing)
- The trust should consider how they intend to meet the individual needs of patients with a hearing impairment due to current challenges associated with the pandemic.
- The trust should consider how they meet the relevant guidance around infection control in the built environment and how this is reflected in their IPC Board Assurance Framework.

Is this organisation well-led?

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

- Most, but not all, of the leadership team had the experience, skills, abilities, and commitment to provide high quality services. Whilst they recognised the training needs of themselves they had not worked to provide development opportunities for the future of the organisation.
- We were not assured the organisational leadership team fully demonstrated the behaviours that reflected the organisational values and we did not see robust plans in place to deliver the strategy.
- There was not a culture of high-quality, sustainable care.

Our findings

- There were not clear responsibilities, roles and systems of accountability to support good governance and management.
- There were not clear and effective processes for managing risks, issues and performance.
- Appropriate and accurate information was not effectively processed, challenged and acted on.
- Staff did not always feel engaged or involved to support high-quality sustainable services.
- Systems and processes for learning and continuous improvement were not always robust.

However, we also found:

- The board and senior leadership team had set a clear vision and values that were at the heart of frontline staff within the organisation.
- There was evidence of good practice in financial management governance.
- People who use services, the public and external partners were engaged and involved to support high-quality sustainable services.
- There was a clear, systematic and proactive approach to research.

Leadership

Most, but not all, of the leadership team had the experience, skills, abilities, and commitment to provide high quality services. Whilst the executive team had recognised the training needs of themselves they had not worked to provide development opportunities for the future of the organisation.

The Trust leadership team included four executive roles appointed since 2019 and six non-executive roles appointed since 2019.

There was not a stable leadership team. Over the last two years, there had been substantial changes to the membership of the trust board. This had led to new members from outside the trust joining the executive team. As a result of unforeseen circumstances, we were told the executive team had little time to bond. For example, the emergence of Covid-19 and the need to socially distance and the heavy reliance on 'virtual' meetings; emerging issues around maternity; an acceleration of the Pathway to Excellence and Magnet processes which demanded significant amounts of senior nursing time and other issues that required oversight and input from members of the executive team including Tomorrows NUH, the defence medical rehabilitation centre (DNRC), financial management, ICS development and service re-design to maintain service delivery.

The board was not working effectively together to achieve its full potential. Individually, most leaders had the skills, knowledge and experience that they needed. However, there was not collective leadership at board level. Whistleblowing information received before, during and after our well led inspection described executive directors working in 'silo' and poor working relationships between certain members of the board. During our interviews with executive (ED) and non-executive directors (NED) we were told where some felt isolated as a result of differing views across the board; that small clusters of executives had been formed thus excluding the wider team and decisions being made that had not been shared and discussed at board.

Some leaders lacked integrity, focusing on the trust's external reputation rather than addressing the challenges to quality and sustainability. Following our inspection of maternity services in October 2020, we were told the executive team were not aware of the issues we had identified during the inspection. However, board papers for 24 September

Our findings

2020 showed where discussions regarding maternity had taken place at board and included a reference to issues being identified as early as January 2018. A week after our inspection of well led, the maternity service was experiencing significant challenges that resulted in needing support from a nearby NHS trust. At this time, as a result of planned leave, there was limited executive oversight of the service with the challenges being addressed locally outside of the executive team.

Staff did not always know who their leaders were or what they did. Leaders were not always visible and approachable. We were told there was a lack of visibility of senior leaders in clinical areas. There was no evidence of a structured senior leadership visibility plan. Information provided following this inspection showed where executive leaders had visited clinical areas however, there was no formal structure to these visits in terms of time spent within an area and frequency of visits. It was also evident from the information provided that there were a significant number of areas across the trust where a visit had not been undertaken.

To gather the views and experiences of staff working at the trust we conducted an online survey. The survey started on 19 July 2021 and was available for two weeks. We received 1,415 completed responses. Results showed, there was a general awareness of who the senior managers were at the trust. However, when asked about effective communication and senior managers acting on feedback, perceptions were more mixed. At the Queen's Medical Centre (QMC) for example, 43% of staff felt senior management did not act on feedback and 44% felt that communication between staff was not effective.

Further results showed, 31% of staff at the trust had confidence in the executive team while 33% of staff reported that they did not have confidence in the executive team (rising to 36% of staff at QMC). Perceptions around how well the organisation implemented change were mixed. At QMC more staff felt negatively about how change was managed than positively, however at Nottingham City Hospital 36% felt change was managed well and 36% felt change was not managed well.

There were leadership development programmes in place. However, the Covid-19 pandemic meant the suspension of programmes with only a limited number of sessions having been completed. Where development sessions had taken place, we did not see evidence of any action taken. For example, following a board development session in July 2020 by the Good Governance Institute.

Appropriate steps had been taken to complete employment checks for executive staff in line with the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). We reviewed the personal files of five executive directors and three non-executive directors to determine the necessary fit and proper person checks had been undertaken. Our checks included the chief nurse, who had been in post for less than two months at the time of this inspection. Board members completed annual self-declaration forms to confirm that they complied with the regulation. All files had an annual declaration within them in line with FPPR. We found most files were fully compliant with FPPR. However, with one executive board member we did not see evidence that a disclosure and barring service (DBS) check had been carried out on this individual before they started employment. In addition, we did not see a DBS risk assessment in place to assist in assessing and recording the risks of allowing this individual to work at this trust.

Vision and strategy

The board and senior leadership team had set a clear vision and values that were at the heart of frontline staff within the organisation. However, we were not assured the organisational leadership team fully demonstrated the behaviours that reflected these values and we did not see robust plans in place to deliver the strategy.

Our findings

The board and senior leadership team had set a clear vision and values. During the core service inspections, we saw staff at all levels understood them in relation to their daily roles. Results of our online staff survey showed, 70% of staff agreed that the trust had a clear vision and values and that they were familiar with them. However, the majority of medical staff {who responded} did not agree with this statement, suggesting a potential disconnect between the organisation and some within this staff group.

'TEAM NUH' (Trust, Empowerment, Ambition, Mindfulness, Nurture, Unity, Honesty) had been developed with staff to articulate the organisation's values and to achieve their overall vision to be "Outstanding in health outcomes and patient and staff experience". Within the trust's 2018-2028 Strategy the trust state, *"We want our values and behaviours to capture what makes working at NUH and being part of 'Team NUH' special. The standards apply to all of us, are part of everybody's job and apply to every action we take, every decision we make and how we care for our patients, their family members, carers and each other".* At the core service inspections, we saw these values embedded into the everyday actions of the frontline staff. However, as a result of conversations with some executives and through information received from whistle-blowers, we were not assured the organisational leadership team fully demonstrated the behaviours that reflected these values.

The trust had implemented their 10-year strategy in 2018, with six key promises on how they intended to achieve their objective of becoming outstanding in health outcomes and patient and staff experience. The trust was in the third year of their ten-year strategy. The strategy was underpinned by objectives and plans for high-quality and sustainable delivery, these were in their infancy and the wider organisation were not engaged with the process. Annual plans had not been communicated across the organisation, and work to strengthen enabling strategies was being undertaken without the benefit of coproduction and so the strategy was not embedded in the delivery of services and colleagues had not been involved to promote a shared purpose.

A long-term financial plan to support and cost the strategy Implementation plan was not visible. Interviews identified that the operational pressures of the COVID-19 pandemic and changes to the financial architecture of the NHS had impacted the production of a long-term financial plan.

The strategy and plans had significant financial gaps that undermined their credibility in relation to achieving the trust's long-term plans for 'tomorrow's NUH'. We were told the condition of the estate impacted on the trust's ability to deliver high quality care; the buildings were designed at a different time to care for fewer patients with different needs than those of today. Through Tomorrow's NUH the trust recognised an opportunity to address those issues. However, a condition survey conducted in late 2020 demonstrated a deterioration in the trust estates backlog from the last survey conducted in 2016. As of July 2021, the backlog sat at £406m. We were told, £500k funding had been allocated to estates facilities management against the original ask of £3.6m through the annual budget setting process.

There was not an effective approach to monitoring, reviewing or providing evidence of progress against delivery of the strategy or plans. When asked if there was a 'Plan B' for the trust if there was a shortfall in financial support for 'tomorrow's NUH', we were told discussions were taking place but were not yet finalised or available publicly.

Culture

There was not always a culture of high-quality, sustainable care.

We found the culture to be top-down and directive. It was not one of fairness, openness, transparency, honesty, challenge and candour. During some of our interviews we found executive staff to be defensive and not compassionate. When something went wrong, we were not assured people were always told and received an apology.

Our findings

There was a disconnect between the board and the wider organisation. We were told there was separation between the board and the divisions and this was the worst it had been in many years. Significant issues had been identified in maternity services as early as January 2018. In October 2020, we imposed conditions on the registration of the provider under Section 31 of the Health and Social Care Act 2008. It was clear from our conversations with the chief executive officer following the 2020 inspection that; the 'ward to board' assurance had not been robust and the executive team had not been following their due processes and holding the division to account.

During this well led inspection we met with a group of non-executive directors who told us they were very aware they had not been exercising their duty to hold the executives to account but had, due to concerns around lack of pace in improvements and reliability of information shared, been stepping into the role that executives should take of holding the divisions to account. This indicates a lack of confidence in how the executive leadership team were performing.

Staff satisfaction across the trust was mixed and not all staff felt supported, respected and valued. During our core service inspection, we found high levels of staff satisfaction. Staff were aware of the challenges experienced within other areas of the trust and how that had impacted the culture but told us the culture in their service could not be different. However, through our interviews, we were made aware of areas where there were low levels of staff satisfaction and high numbers of staff feeling overworked. We were told some staff were fearful of raising concerns.

Results of our online staff survey showed, 53% of staff at Nottingham City Hospital (NCH) felt satisfied that the organisation valued their work. However, when asked if the organisation provided effective support to carry out their role to the best of their ability, only 41% of staff at Nottingham City Hospital agreed with this, while 38% disagreed. Staff at QMC felt less valued than those at NCH, with only 44% feeling satisfied that their work was valued by the organisation. When asked about whether they felt they were effectively supported to do the best job they can by the organisation, a greater proportion of staff felt they were not supported (44%) than those who agreed that they were effectively supported (33%).

The trust continued to face considerable challenge in embedding and sustaining a culture of high quality sustainable care in its maternity service. During a focused inspection of maternity services in October 2020. We found the service fell short of the trust values and met staff who reported feeling unsupported, respected and valued. The culture amongst staff in this service had been on the decline since 2018. The trust response to cultural concerns within this service had been slow. During the well led inspection, we received calls from a number of staff who wanted to escalate their concerns to us directly. Staff who spoke to us appeared fragile and told us they felt unsupported and unable to raise concerns despite actions taken by CQC immediately following the 2020 inspection.

The response rate to the 2020 national staff survey was below the national average, indicating a reluctance of staff to engage with the trust. A lower response rate also means that results are less likely to be representative of all staff at the trust. The trust achieved a response rate of 35%, a decrease of 3% on 2019 and below the Acute Trust and Acute and Community Trusts average of 45%, which it had been below since 2016. However, the results represented an improvement on the 2019 national staff survey with increases of between 0.1 and 0.3 (out of a total score of 10) noted across 5 themes.

There was a culture of bullying across the organisation. In two separate forums we were told of bullying incidents occurring across the trust with a 'lack' of ability to address or resolve incidents in a timely fashion and that culture, policies and procedures did not provide staff with adequate support.

Our findings

We were told of a number of bullying cases were directly attributable to racial discrimination. The trust's latest staff survey showed; the trust was above average for Black, Asian and Minority Ethnic staff experiencing bullying or harassment. The large gaps between white and Black, Asian and Minority Ethnic staff in terms of % experiencing of bullying and harassment from other staff was higher than the national average for acute trusts.

The trust had two Freedom to Speak Up Guardians (FTSUG) who supported staff to speak up when they felt unable to do so by other routes. The FTSUG reported to the board twice a year. In the 12 months to March 2021, there were 79 contacts made to the FTSUG, compared to the 51 contacts in the previous year. Themes of concerns raised through FTSUG included; bullying, lack of civility, staff not listened too, poor behaviours, some staff too frightened to speak up and staff being treated differently due to race. During an interview with a member of the executive team we were told the board were not aware of bullying concerns.

Results of our online staff survey showed, 56% of staff at the trust felt safe to report concerns without fear, however, only 45% of staff felt confident raising these concerns through the trust's FTSUG. Staff who had been with the organisation for less than one year appeared most unsure about the FTSUG, however it was more longstanding staff who were most likely to feel unconfident about raising concerns through the FTSUG. Doctors were the staff group who felt most unsafe about raising concerns without fear of repercussions.

There was a challenging relationship with the Coroner with issues around information sharing, openness and transparency. This had also been reflected when commissioners and regulators had sought additional assurances for example, learning from incidents and action plans or, requested to be part of internal meetings in order to reduce assurance burden and instead shift to a culture of working together and seeking assurances around internal arrangements rather than the individual case detail.

The trust had established shared governance throughout its services. The shared governance programme was designed for staff to have a voice and decision making at point of care, and also share professional decision making with the most senior leaders across the trust. However, we heard that this process had led to false assurance being taken which indicates insufficient rigor and challenge by leaders.

Pharmacy staff found the senior leadership team approachable and were able to talk to any staff in management, not just their line manager. They felt cared for by both their own team and the wider trust. They received support through emails from the trust chief executive officer with information on a wide range of wellbeing topics and were aware of the trust's counselling service.

The executive team told us they were committed to the safety and wellbeing of staff and had a staff wellbeing programme which included dedicated staff physios, fitness facilities and staff benefits. The Staff Wellbeing programme team provided a range of training including for example, psychological first aid, react mental health conversation training for line managers, 'leading a healthy workforce' training for managers, living well with stress, anxiety workshops and a variety of positive lifestyle choices workshops for managing wellbeing.

Governance

There were not clear responsibilities, roles and systems of accountability to support good governance and management. However, there was evidence of good practice in financial management governance.

Corporate and clinical governance were not working together to provide effective oversight of risks and issues to drive improvements in health care and executive leaders did not appear to recognise how the two were linked. As a result,

there was a lack of communication and respect between the two systems inside the organisation. Corporate governance covered many matters that were not covered in clinical governance. Matters such as trust policies and procedures, risk management, the board assurance framework, emergency planning and health and safety all fell under corporate governance. Yet, these matters supported patient care, practice processes and healthcare procedures that the trust needed to serve patients and support the delivery of the strategy and good quality, sustainable services.

We were told, as of end of June 2021, there was a backlog of open patient safety incidents (3,858). We were told that there had been no risk stratification of these as yet to understand any risk. We were told that the trust reported a greater number of 'low' or 'no harm' incidents when compared to other trusts and there was a concern that harm was not being appropriately assessed when patient safety incidents were being raised. This was found in maternity in October 2020 and the trust was yet to take effective action which would provide assurance that incidents were correctly identified, investigated and apologies given where needed.

Information reported up through governance was not always reliable and of sufficient quality to lead change. The reporting of incidents to a national central system helps protect patients from avoidable harm by increasing opportunities to learn from mistakes and where things go wrong. With the current trust backlog of open {not yet investigated} incidents there was a missed opportunity to prevent the likelihood of similar incidents happening again.

Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Duty of candour requires registered providers and registered managers (known as 'registered persons') to act in an open and transparent way with people receiving care or treatment from them. We were not assured the trust were discharging their responsibilities appropriately under this regulation as the trust were not aware if any of the 3,858 open patient safety incidents were notifiable safety incidents.

Performance data for maternity services suggested a risk of avoidable harm to mothers and babies in as early as January 2018, this had not been acted upon and there had been no real recognition by the executive team until after our October 2020 inspection.

There was complaint sign posting and a complaint policy available on the trust's website for patients and services users to access. During our inspection of well led we reviewed five complaint responses. Three out of the five incorrectly addressed the complainant in their apology when the complaint was on behalf of a relative. Some of the responses lacked empathy and or contained complex medical terminology that was not explained. None of the complaint responses had action plans attached and there was limited description of any actions that were going to be taken as a result within the body of the letters. One complaint response was brought to the attention of the Chief Nurse in relation to a patient who had undergone treatment that was not required due to misidentification. The complaint response did not provide detail regarding how this had been investigated or what particular actions were going to be taken. Over the last five years there were reoccurring divisions that had the highest number of complaints, there was no evidence that any analysis of this had been undertaken to understand this.

The Trust had well-established financial management and financial governance arrangements. The finance team was experienced and well regarded and had a clear ethos, structure and processes for continued development and learning. The team had developed strong links with clinical colleagues and demonstrated a strong culture of continuing clinical engagement in financial matters.

The trust had historically delivered the financial expectations agreed with it. There was evidence of good practice in financial management governance that could be replicated in other areas of governance and oversight within the trust, particularly in oversight of divisions and pathways.

Our findings

There was documentary, and interviewee reported, evidence of delays in decision making. These delays might be attributable to deficits in non-financial performance indicators and a lack of visibility and triangulation of risks that might affect the delivery of the trust's key strategic objectives. These factors might also impact the ability of the trust to identify, analyse, obtain insight, develop mitigation, and take timely action to address emerging risks.

There were clear lines of communication and accountability between the chief pharmacist and the board. Medicines risks within the trust were raised through the medicines governance committee. A biannual medicines optimisation assurance report was presented to the quality and safety committee. The chief pharmacist took urgent risk concerns direct to the medical director.

Management of risks, issues and performance

Processes for managing risks, issues and performance were in place. However, these were not always clear and effective.

Performance issues were not always escalated appropriately through clear structures and processes. Oversight of the maternity services and the management of performance issues had not been sufficiently robust to allow known issues to be addressed.

The director of corporate governance had delegated authority for the risk management framework and was the lead for maintaining the Board Assurance Framework (BAF) significant risks register and supporting processes. Recorded risks were aligned with what staff said were on their 'worry list'. The trust board had sight of the most significant risks through the BAF and significant risk register.

Arrangements for identifying, recording and managing risks, issues and mitigating actions were in place. However, these were not always clear and effective. A review of board and committee papers identified potential indicators of organisational capacity constraint. In December 2019, a CQC report included a 'should do' action to review nursing ratios in the Neonatal service against the British Association of Perinatal Medicine (BAPM) standards. On 3 November 2020, the Getting it Right First Team (GIRFT) report raised a similar issue. A paper requesting additional investment in nursing was received by the finance and performance committee in April 2021. The risk score within this paper was 20. The elapsed time between December 2019 to April 2021 was significant for a high-risk issue. At the time of this inspection and through our conversations with executives, it was unclear whether this risk was being visibly escalated to corporate risk registers or whether the risk was of such significance as to warrant consideration in the BAF. Information received following our inspection confirmed, the BAPM standards risk was on the trust significant risk register.

There were two risks described on the BAF that were intrinsically linked with no indication that the relationship between the risks was recognised or adequate mitigations were evidenced. We found there was limited evidence of effective and timely actions being taken when risks had been identified or holding to account for such actions. In addition, the BAF lacked the date of strategic risk entry so there was no ability to see how long a strategic risk had been present.

A programme of monthly performance reviews was in place for divisions where they were held to account for their performance against the trust's agreed quality and performance targets, and with compliance against expected standards in each of their clinical services.

The medicines safety committee had a manageable remit. They worked well with the patient safety team however, no one from the patient safety group sat on the medicine's safety group.

Our findings

Whilst the lack of electronic prescribing limited the metrics that the trust could benchmark against, the trust benchmarked itself against NHS benchmarking data, Model Hospital and IQUVA.

The pharmacy service shared incidents with the medicines safety officer network. Medicines incidents safety reports show how they benchmarked against other hospitals. The medicines safety officer reviewed all incidents reports to ensure that their harm rating was accurate. In addition, they attended the weekly incident review meetings when medicines related incidents had occurred.

Information management

Appropriate and accurate information was not always effectively processed, challenged and acted on.

There was not a holistic understanding of performance. Progress against the annual plan goals and BAF was monitored on a quarterly basis and the integrated performance report on a monthly basis. These were undertaken as separate progress reports.

The 'annual plan progress' report was a quarterly report which went to the trust board, providing on overall assessment of the trust's annual goals, including insights from BAF risks and performance (KPIs).

The trust's integrated performance report was a monthly report which went to the trust board, providing an oversight of performance against all business-critical performance indicators. We were told that there was lack of confidence in the data quality and dissatisfaction with the current integrated performance report.

The quality of information and assurance was not effective and there was a lack of professional curiosity and challenge. A review of board and sub board committee papers showed limited triangulation of information for example; quality, workforce and finance, to assist effective understanding and mitigation of risk. There was limited evidence of effective and timely actions being taken when risks had been identified or holding to account for such actions. We were told that papers to board were often "reduced in content or sanitised before going to board".

Reporting against the trust's strategic objectives showed a number of areas that were off track. The Covid-19 response continued to impact on the trust's workforce through April to June 2021. However, some factors predated Covid-19, such as problems with the eLearning portal and the impact on mandatory training. Sickness absence c.4.2% was above target (3.6%) and mandatory training c.79% below target (90%). Training and development of staff was a key BAF risk, which was not being achieved in some areas due to the backlog in appraisals and access to large training room facilities to accommodate social distancing for training.

Information technology systems were not always effective; Electronic Staff Record (ESR) data was creating issues with mandatory training compliance. Works had commenced on developing a fundamental review of ESR, with (external) investment required to progress this at pace. Information technology systems were not used effectively to monitor and improve the quality of care for women and babies. At our October 2020 inspection, we identified, use of multiple systems meant information needed to deliver safe care and treatment was not always available to relevant staff in a timely and accessible way. During our focused follow-up inspection in April 2021 we found very little improvements had been made; multiple systems remained in place for staff to document in, which led to duplication and errors at times, community midwives described the electronic system used in the acute trust as slow, and the midwives could not always access it online due to connectivity issues. All the midwives told us the electronic system took an extra 25% to 30% of their time, which detracted from the time spent with women.

Our findings

The Data Security and Protection Toolkit (DSPT), developed by NHS Digital (NHSD), sets out the standards and requirements in respect of receipts, storage and processing of information. The DSPT is structured into a series of numbered criteria. The DSPT is completed on a self -assessment basis each year. NHSD had extended the submission date for the 2020/21 DSPT from 31 March 2021 to 30 June 2021 however, we were told the improvements from 2019/20 continued to be work in progress and had yet to be fully delivered. As such, the trust felt it unlikely that they would meet all standards by 30 June 2021, and would again require an improvement plan, which NHDS would need to approve.

Six serious breaches were reported to the Information Commissioner's Office (ICO) between 01 April 2020 and 31 March 2021. One key area of concern related to inappropriate use of system access by staff, which led to disciplinary action. As a result, a number of all staff communications was undertaken from the information governance team, Caldicott guardian and the board.

Overall, significant progress had been made during April to June 2021 (Q1) to restore services, with elective, day case and outpatient activity levels reaching the highest weekly levels since the start of the pandemic. In line with national guidance, the trust were treating patients in order of clinical priority and had reduced the number of priority two and three patients that had breached their recommended wait time for an admitted procedure. The trust had also reduced the number of patients waiting over 52 weeks.

As Covid-19 restrictions eased during Q1, the trust saw heightened levels of non-elective and cancer referral demand which placed pressure on services and compromised the delivery of some of the trust's constitution time-based access standards.

The total diagnostic backlog of patients waiting six weeks and over had reduced during Q1 with steady progress to improve performance against the diagnostics waiting times and activity (DM01) standard. It was to take time for performance against key constitutional elective care standards for example, 18 weeks RTT, to fully recover due to the size of the backlogs that had developed during the pandemic. The trust had continued to deliver non-face to face appointments (c.30%, target 25%), same day emergency care (c.35%, target 30%) and heightened levels of advice and guidance activity.

Managing the BAF risk of nosocomial Covid-19 infections continued to be a challenge due to an increase in footfall in some clinical environments as elective activity had resumed, excessive bed movements and the more infectious Delta variant. This was being managed by encouraging clinical teams to change the way in which they worked in managing patient appointments, continuing to minimise waiting times and minimising patient bed moves.

Engagement

People who use services, the public and external partners were engaged and involved to support high-quality sustainable services. However, staff did not always feel engaged or involved.

The trust had taken a pivotal leadership role in setting up an 'Acute Provider Collaborative' in partnership with a local NHS trust. The East Midlands Acute Providers (EMAP) network board had been supported by all eight acute provider trusts and aimed to collaboratively pursue best outcomes for the population across the East Midlands.

The trust had sustained their targets in achieving >90% positive patient experience obtained through feedback from the Family and Friends Test (FFT) Survey. However, collating themes and trends had only recently been recognised;

therefore, the trust had launched an online survey to broaden their approach to patient engagement and increase accessibility. This was to support the trust's ability to understand the key themes at both a local and trust level through an improved dashboard. The trust held 62 patient and public involvement events April to June 2021, alongside the appointment of 17 patient volunteers to support the delivery of the 'Tier 1 Quality Improvement Programme'.

The integrated care system (ICS) Health Inequalities and Prevention Committee had been established during April to June 2021 with trust representation from the medical director and chief people officer. The trust was working with ICPs to deliver localised priorities with a prevention focus, including Covid-19 vaccinations, flu vaccinations and stop smoking services.

Progress was being made to develop the trust's approach towards specialised service delivery, including the development of draft specialised services priorities, engagement with local and regional commissioners on future direction and priorities and, the set-up of hosting arrangements for four new clinical regional networks (neurosurgery, cardiac, renal and Childrens and young people with cancer). The trust was establishing a hosting function and had commenced recruitment of key posts within the clinical network development.

Staff did not always know who their leaders were or what they did. Leaders were not always visible and approachable. We were told there was lack of visibility of senior leaders in clinical areas.

The wider organisation was not engaged with the objectives and plans underpinning the strategy. Annual plans had not been communicated across the organisation, and colleagues had not been involved to promote a shared purpose.

We found the culture to be top-down and directive with a disconnect between the board and the wider organisation. Staff satisfaction across the trust was mixed and not all staff felt supported, respected and valued. In some areas there were low levels of staff satisfaction and high numbers of staff feeling overworked. We were told some staff were fearful of raising concerns.

The culture amongst staff in the maternity service had been on the decline since 2018. The trust response to cultural concerns within this service had been slow. During the well led inspection, we received calls from a number of staff who wanted to escalate their concerns to us directly. Staff who spoke to us told us they felt unsupported and unable to raise concerns despite actions taken by CQC immediately following the 2020 inspection of maternity services.

The response rate to the 2020 national staff survey was below the national average, indicating a reluctance of staff to engage with the trust. The Trust achieved a response rate of 35%, a decrease of 3% on 2019 and below the Acute Trust and Acute and Community Trusts average of 45%.

There was a culture of bullying across the organisation including cases directly attributable to racial discrimination. There was a 'lack' of ability to address or resolve incidents in a timely fashion and that culture, policies and procedures did not provide staff with adequate support.

Themes of concerns raised through the freedom to speak up guardians included; bullying, lack of civility, staff not listened too, poor behaviours, some staff too frightened to speak up and staff being treated differently due to race.

Learning, continuous improvement and innovation

Systems and processes for learning and continuous improvement were not always robust. However, there was a clear, systematic and proactive approach to research.

Our findings

In December 2016, the Care Quality Commission published its report 'Learning, candour and accountability': A review of the way NHS trusts review and investigate the deaths of patients in England. The report identified that there were inconsistencies in the way acute trusts carried out mortality reviews and there was a need to improve learning from deaths reviewed. The national guidance on learning from deaths (March 2017) subsequently provided a framework for NHS trusts on identifying, reporting, investigating and learning from deaths in care.

As part of this inspection we looked at the trust's processes for reviewing deaths. The inspection teams' overall opinion was that structured judgment reviews demonstrated that data was candidly captured with good resources and capabilities along with standard processes in place.

Repeat harm incidents were a key area of concern in maternity and an indicator that the trust had not been sufficiently learning or embedding sustainable change. This was reflected with the BAF risk (16 score) remaining unchanged for making sustainable improvements from incidents, complaints, claims and inquests which may cause undue or preventable harm. We were told significant work was underway to address these issues. However, with a total incident backlog of 3,858 open patient safety incidents, we were not assured the 'significant work' was robust enough to review these at pace. Data availability and learning opportunities were in place for patient complaints, serious incidents, inquests and mortality reviews, however work to triangulate and map themes across all areas was still required.

The trust hosted a significant number of clinical research studies every year, including complex clinical trials. More than 300 doctors, nurses and health professionals were involved in clinical research, ensuring that the benefits of new treatments, drugs and therapies translated from the research laboratory directly into clinical practice. Much of the trust's research was done in collaboration with other hospitals, research centres and through national and international partnerships.

In 2020, Nottingham City Hospital was the first in the United Kingdom (UK) to earn Magnet accreditation from the American Nurses' Credentialing Center (ANCC). The accreditation offered by the ANCC is often referred to as the gold standard for healthcare organisations and demonstrates a culture of shared decision-making, education and development for nurses. To become a Magnet recognised hospital, the trust submitted a comprehensive improvement plan, nursing care, patient experience, and staff experience outcomes were monitored for two years and a four-day virtual site visit was undertaken by Magnet appraisers. In early 2020, the trust also earned the Pathway to Excellence accreditation for its paediatric services.

From early in the Covid-19 pandemic the trust had worked closely with the University of Nottingham to undertake whole genome sequencing (WGS) of Covid-19 samples. This included any patients or staff tested at the trust. This helped the trust in recognising if variants of concern were present and supported how outbreaks had been managed. The infection prevention and control team used epidemiological methods to assess likely cross transmission. By using WGS this had highlighted areas that were not originally apparent, allowing connections to be made and allowing further interventions on patient pathways.

External and internal benchmarking tools, including Patient Level Information Costing Systems (PLICS) and the NHS Model Hospital toolkit were extensively utilised. The trust was one of the highest users of the Model Hospital toolkit in England. The trust was an advanced user of PLICS information and presented multiple views of service costs to service lines utilising Sankey diagram visualisation and a user area known as 'the sandpit'. Clinical engagement between the finance function and clinical leaders was strong and the use of multiple clinical and corporate benchmarking sources was exemplified in recent work with the plastic surgery pathway.

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

Month Year = Date last rating published

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ➔➔ Sep 2021	Requires Improvement ↓ Sep 2021	Outstanding ➔➔ Sep 2021	Requires Improvement ↓ Sep 2021	Inadequate ↓↓ Sep 2021	Requires Improvement ↓ Sep 2021

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

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Nottingham City Hospital	Requires Improvement ➔🡐 Sep 2021	Requires Improvement ➔🡐 Sep 2021	Outstanding ➔🡐 Sep 2021	Good ➔🡐 Sep 2021	Requires Improvement ➔🡐 Sep 2021	Requires Improvement ➔🡐 Sep 2021
Ropewalk House	Good Mar 2016	Not rated	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Queen's Medical Centre	Requires Improvement ➔🡐 Sep 2021	Requires Improvement ➔🡐 Sep 2021	Good ➔🡐 Sep 2021	Requires Improvement ➔🡐 Sep 2021	Requires Improvement Sep 2021	Requires Improvement ➔🡐 Sep 2021
Overall trust	Requires Improvement ➔🡐 Sep 2021	Requires Improvement 🡓 Sep 2021	Outstanding ➔🡐 Sep 2021	Requires Improvement 🡓 Sep 2021	Inadequate 🡓🡓 Sep 2021	Requires Improvement 🡓 Sep 2021

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

Rating for Nottingham City Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019
Critical care	Good Mar 2016	Good Mar 2016	Outstanding Mar 2016	Good Mar 2016	Outstanding Mar 2016	Outstanding Mar 2016
End of life care	Good Mar 2019	Requires improvement Mar 2019	Outstanding Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019
Outpatients and diagnostic imaging	Good Mar 2016	Not rated	Good Mar 2016	Requires improvement Mar 2016	Good Mar 2016	Good Mar 2016
Surgery	Good ➔🡐 Sep 2021	Good ➔🡐 Sep 2021	Good ➔🡐 Sep 2021	Good ➔🡐 Sep 2021	Good 🡓 Sep 2021	Good ➔🡐 Sep 2021
Neonatal services	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019
Maternity	Inadequate Dec 2020	Inadequate Dec 2020	Good Mar 2019	Good Mar 2019	Inadequate Dec 2020	Inadequate Dec 2020
Overall	Requires Improvement ➔🡐 Sep 2021	Requires Improvement ➔🡐 Sep 2021	Outstanding ➔🡐 Sep 2021	Good ➔🡐 Sep 2021	Requires Improvement ➔🡐 Sep 2021	Requires Improvement ➔🡐 Sep 2021

Rating for Ropewalk House

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients and diagnostic imaging	Good Mar 2016	Not rated	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Overall	Good Mar 2016	Not rated	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016

Rating for Queen's Medical Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Mar 2019	Good Mar 2019	Good Mar 2019	Outstanding Mar 2019	Good Mar 2019	Good Mar 2019
Services for children & young people	Good Mar 2019	Good Mar 2019	Good Mar 2019	Requires improvement Mar 2019	Good Mar 2019	Good Mar 2019
Critical care	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Outstanding Mar 2019	Good Mar 2019
End of life care	Good Mar 2019	Requires improvement Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019
Outpatients and diagnostic imaging	Good Mar 2016	Not rated	Good Mar 2016	Requires improvement Mar 2016	Good Mar 2016	Good Mar 2016
Surgery	Good →← Sep 2021	Requires Improvement ↓ Sep 2021	Good →← Sep 2021	Good →← Sep 2021	Good ↓ Sep 2021	Good →← Sep 2021
Urgent and emergency services	Requires Improvement →← Sep 2021	Good Mar 2019	Good Mar 2019	Requires Improvement →← Sep 2021	Requires Improvement ↓ Sep 2021	Requires Improvement →← Sep 2021
Maternity	Inadequate Dec 2020	Inadequate Dec 2020	Good Mar 2019	Good Mar 2019	Inadequate Dec 2020	Inadequate Dec 2020
Overall	Requires Improvement →← Sep 2021	Requires Improvement →← Sep 2021	Good →← Sep 2021	Requires Improvement →← Sep 2021	Requires Improvement Sep 2021	Requires Improvement →← Sep 2021

Nottingham City Hospital

Hucknall Road
Nottingham
NG5 1PB
Tel: 01159691169
www.nuh.nhs.uk

Description of this hospital

Nottingham City Hospital is part of Nottingham University Hospitals NHS Trust. The hospital serves as the regional centre for cancer care, nephrology, infectious diseases, cardiology, cardiothoracic surgery and burns; and is a national centre for shoulder surgery. It also serves as the hyperacute stroke unit, respiratory medicine unit, and elective urology centre for Nottingham.

The surgery service provides both elective and emergency surgery. Specialist surgery provided at the hospital includes plastics and burns, breast, thoracic, cardiac, renal, urology, gynaecology and elective (planned) orthopaedic surgery. There are 23 operating theatres.

During our inspection we visited Harvey 1, Harvey 2, Edward 2, Patience 2, Winifred 2 and Morris wards. We also went Main Theatre, Surgical Pre-Operative, Main Theatre Admissions, the Day Case Unit, Cardiac Theatres, Cardiac ICU, the Discharge Lounge, the Burns Unit and the Barclay Thoracic Unit.

We spoke to 41 members of staff including doctors and nursing staff of various grades, healthcare support workers, physiotherapists and managers. We spoke to 17 patients and we looked at 33 sets of patient records.

Surgery

Good

Is the service safe?

Good

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

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. However, some training had been deferred due to the pandemic.

Not all staff were up to date with their mandatory training. We were made aware of the impact of COVID-19 on mandatory training as much was suspended at the peak of the pandemic. While many of the individual managers and staff indicated high levels of compliance, figures provided by the trust following the inspection showed an overall compliance of only 73% against a trust target of 90%. Figures for individual groups of staff varied widely from as low as 50% to 98% and there were discrepancies across types of training. For example, the practical parts of moving and handling training was difficult to achieve safely. However, we noted that recovery plans were in place and there was an expectation that targets would be met by March 2022. New staff were targeted for this training so any training that was missed was refresher training.

The mandatory training was comprehensive and met the needs of patients and staff. Training was provided through a mix of electronic and face to face training although the latter had reduced due to COVID-19 distancing requirements. Staff were positive about their training.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Staff to whom we spoke were confident in dealing with these issues and referred to their training. On the pre-operative ward, we saw the use of mini-mental health assessments as part of the frailty package used for some patients.

Managers monitored mandatory training and alerted staff when they needed to update their training**.** All managers we spoke to were aware and honest about of any shortfalls in mandatory training due to the COVID-19 pandemic and had plans to recover from this. In some locations this was facilitated by clinical educators.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Mandatory safeguarding training had been affected by the COVID-19 pandemic and there was a programme to recover by March 2022. This was reflected in the compliance figures we saw where the modules that needed to be completed every three years were at a much higher level than those that were required yearly. New staff were targeted for this training so any training that was missed was refresher training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff were notably confident and knowledgeable about these matters,

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. They were often able to give examples of when they had raised issues, and these demonstrated good practice.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. With very few exceptions staff were able to describe the circumstances in which they would contact the local authority or the police directly.

Staff followed safe procedures for children visiting the ward. Visiting was restricted during our inspection. Nevertheless, staff were familiar with the risks to children and some of the safeguarding examples we were given concerned domestic violence where there were children in the home.

Cleanliness, infection control and hygiene

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

The trust had implemented systems to ensure that the risk of infection was minimised during the COVID-19 pandemic. Following the inspection, we asked for audits of surgical site infections and it was clear that a comprehensive audit programme was in place.

All areas were clean and had suitable furnishings which were clean and well-maintained. Although some areas appeared “tired” due to the age of the estate. There was an ongoing refurbishment programme and on some wards we saw a clear difference, in, for example, bathrooms before and after renovation.

The service generally performed well for cleanliness. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We saw cleaning audits, including special COVID-19 audits and cleaning checklists on notice boards and in use by cleaning staff.

Staff followed infection control principles including the use of personal protective equipment (PPE). On the thoracic unit we saw a non-clinical member of staff, who nevertheless entered patient areas was not bare below the elbow and we drew this to the attention of the manager who immediately addressed the issue.

Patients suspected of having infection were isolated in side rooms and cared for using appropriate techniques. The rooms were clearly labelled to indicate the type of infection and the precautions needed.

COVID-19 specific procedures were also well adhered to and there was plenty of sanitiser and additional PPE available throughout the wards and public areas. Rooms were assessed as to safe occupancy levels and this was displayed in a very clear way on each door. Staff complied with these requirements including in rest rooms. However, we noted that on Patience 2 room numbers were not always adhered to and in main theatres lack of space meant safe numbers for staff rest areas were low.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff were observed to be diligent in this and we also noted that staff were tasked to carry out regular, supplementary cleaning. We also saw staff doing this for equipment they used themselves, particularly computer terminals.

Surgery

Staff worked effectively to prevent, identify and treat surgical site infections. The trust had policies that were in line with national guidance from The National Institute for Health and Care Excellence (NICE). There were pathways for specific surgical specialities and staff received training and were knowledgeable about their own areas. For example, on the plastic surgery ward staff discussed the treatment of bites and lacerations from tools and told us how they offered support to other wards.

Surgical infections were considered as serious incidents and were discussed at divisional level.

Environment and equipment

The maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, the original design of the hospital meant this was challenging.

Patients could reach call bells and staff responded quickly when called. We saw call bells in place for patients and several told us that staff always responded to call bells.

The design of the environment did not always follow national guidance. The City Hospital had buildings ranging from those that were newly built to those more than one hundred and twenty years old. This meant that some requirements were difficult to accommodate when a building was renovated. For example, the provision of side rooms for the control of infection and to allow privacy.

The trust had a refurbishment plan to address the issues and we saw examples where the this made a significant difference to patients.

Fire precautions were in place with good signage and we did not note any escape routes being blocked. The corridors were noticeably free of material that might both impede escape and, itself, present a fire risk.

Staff carried out necessary checks of specialist equipment. Staff were easily able to identify if equipment had been serviced and was safe to use. We examined the ward records for devices that needed to be checked each day such as resuscitation equipment and emergency drugs and it was clear that this was done diligently.

We were also aware of significant problems in the main operating theatres where ventilation equipment was unreliable and resulted in the cancelation of operations.

The service had suitable facilities to meet the needs of patients' families. However, due to the COVID-19 pandemic very few relatives visited and fewer were encouraged to stay meaning some of these rooms had been repurposed because of the lack of space.

The service had enough suitable equipment to help them to safely care for patients. There was an equipment library and specialist pressure mattresses were usually available within 30 minutes all day, every day.

Staff disposed of clinical waste safely. There were sufficient and suitable clinical and domestic waste bins as well of those for “sharps” and we noted they did not become overfull. Waste was suitably stored and taken away, so that it did not build up.

Assessing and responding to patient risk

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

Surgery

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The revised version of the National Early Warning Scoring System (NEWS2) was in use across the trust and implemented on the organisation's Electronic Patient Record (EPR) system. Staff could access this through handheld devices, and these were used to input observations and results. NEWS2 scores were calculated automatically and alerts generated. There was also a system where patients who met certain criteria were alerted to the Critical Care Outreach Team who were in a position to assess and support the needs of poorly patients.

We noted though examining both electronic and paper records that NEWS2 scores were noted and acted upon. It was also noted that the system was supporting the staff in their work and not constraining them. For example, staff could always escalate patients on the basis of their concerns even if they did not meet the threshold for escalation.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Risk assessments were also implemented on the electronic system and we noted that they were completed correctly. The system was self-auditing and prompted staff to review assessments either on the basis of lapsed time or event

However we noted that while some elements within the surgery core service such as Ambulatory Care and Cardiac Surgery were largely meeting the trust's 95% completion target for Venous Thromboembolism (VTE) assessment over the last 6 months, in cancer they were largely not, and in the case of the surgery division no month met the target.

We discussed how COVID-19 had affected pre-operative assessment and many specialities had moved to virtual assessment facilitated through pre-operative clinics at the Queens Medical Centre. This had proved successful with 50% of patients not needing to attend in person prior to surgery and would continue. For orthopaedic patients the approach was less successful for factors such as the ability of the group of patients to use the technology and that their health usually required them to come in anyway for tests. As a result, the system was only being used for around 20% of patients who tended to be younger and needing only minor surgery.

We also saw that patients were risk assessed and if necessary given a programme to get them fit for their surgery. The elective pre-operative clinics had access to a geriatrician who also held clinics for some older patients.

Staff knew about and dealt with any specific risk issues. However, compliance with the sepsis bundle for high risk sepsis was low and we noted several instances where the WHO surgical checklist had not been fully completed, largely failure to "sign out". Following the inspection, we saw an audit report dated January 2020 where this issue was noted, and it was clear some 18 months later this was still the case. Staff were very confident in their knowledge of sepsis and they were supported in this by the trusts EPR system that identified patients with concerning scores and / or observations. When we looked at patient records, we saw that patients of concern had been identified and the concern acted on.

The trust carried out sepsis audits and we were provided with results following the inspection. We noted that for the year to date in the surgery division the compliance for all actions carried out was 47%. The variance in patient numbers each month made it difficult to compare the percentage findings.

Staff were aware of new and emerging risks including recent themes of falls, rising pressure area concerns and a tendency of patients to be more unwell and to deteriorate faster. In the case of falls it had been suggested that elderly patients who had been mainly at home during the pandemic had become physically weaker, and this risk was being accounted for. There was an increased awareness of pressure area care and most staff mentioned it when asked about concerns.

Surgery

There was varied compliance with the WHO surgical checklist with some records we saw being exemplary and others with “stop moments” missing. When we talked to senior leaders they told us that they were working to establish “stop moments”.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff were aware of the signs to be aware of and had access to specialist knowledge. The Burns Unit had its own psychologist.

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.

Nurse staffing

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

We observed that the service had enough nursing and support staff to keep patients safe. Ward managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. However, we asked the service to provide staffing information following our inspection so we could see the staffing levels on individual wards, but it was not provided.

The department manager could adjust staffing levels daily according to the needs of patients. During the inspection we saw the thoracic ward had enhanced staffing in place because of five high dependency patients and two others who were confused on the ward.

The number of nurses and healthcare assistants matched the planned numbers. We saw many areas displayed the actual staffing vs the requested staffing for each shift on a board and we did not see any significant discrepancies.

The service had low vacancy rates. Senior managers said they had vacancy rates of 23% for band 5 nurses across the trust but we did not see this affecting patent care at the City Hospital. The trust also offered training opportunities, such as a nurses’ anaesthetic programme as part of the job offer to attract staff.

The service had low turnover rates. However, one ward had lost a high number of staff, but this was because they had enjoyed working on the critical care units and wished to progress their careers there. There was a turnover rate of 8% across the trust and “rolling adverts” were in place so recruitment was always open.

The service had nominal sickness rates of 4.5%. The data we saw indicated falling sickness levels at the time of the inspection following high levels during the peak of the pandemic which were higher than for the rest of the trust.

The service had low rates of bank and agency nurses. Managers limited their use of bank and agency staff and requested staff familiar with the service. Nurses were redeployed or obtained from the nursing bank. We were told that no agency staff were used in theatres at the City Hospital and this was corroborated to some extent by information the trust sent us following the inspection.

Managers made sure all bank and agency staff had a full induction and understood the service. Trust policy was that all agency staff had an induction to their workplace and we were told us this was the case, but we were not able to clarify this by talking to agency staff.

Surgery

Medical staffing

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

The service had enough medical staff to keep patients safe, medical staff matched the planned number and the service had low and vacancy rates for medical staff. Where staff expressed concern, it was in getting doctors to assess and prescribe for discharge and we were told they would quickly attend for a poorly patient.

Medical staff were positive about working at the trust. We came across a number of examples where staff had either stayed or planned to stay at the trust following their training because of good experiences.

Sickness rates for staff were low at 1% for medical staff in the surgery division. In other divisions that performed surgery numbers were slightly higher but not outside of nominal values compared to the rest of the country. We noted that sickness had increased in line with peaks of the COVID-19 pandemic.

The service had low rates of bank and locum staff and 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. We were told consultant support was available to junior staff and following the inspection the trust provided information to demonstrate that out of hours there was always a suitable consultant on call for each speciality.

Records

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

Patient notes were comprehensive and all staff could access them easily. We looked at 33 sets of notes and they were almost always of a good standard. We noted that there were signature logs on paper notes so the person signing might be easily identified.

When patients transferred to a new team, there were no delays in staff accessing their records. The use of an EPR system ensured that electronic notes were available throughout the hospital whatever the patient's location. Where patients were transferred any paper records went with them.

Records were mostly stored securely. However, we noted that some paper records were stored in transparent holders on the walls of the ward near to the patient's bed. While they were easily accessible and under the eyes of staff it was possible for anyone to pick them up. Other records were stored in trolleys and these were not always locked.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. However, on one ward medicines were frequently stored at too high a temperature.

Surgery

Antibiotics were prescribed against protocols which reflected good practice for anti-microbial stewardship and the trust audited performance against these standards. Where shortfalls against the inspected standards for each ward were noted there were honest comments together with actions to be taken.

Controlled drugs were stored securely. Drugs were stored in suitable locations although on the thoracic ward the drugs cupboard was small and hot meaning drugs were stored at the wrong temperature. Staff said they had reported this, and when it happened got advice from pharmacy colleagues but that nothing more had been done.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.There was regular review and reconciliation of medicines by pharmacy staff who had regular wards with whom they worked. Specific drugs, such as antibiotics required regular review, and this was often aided by checklists within documentation.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. We looked at 33 patient records and they were properly completed. However, although medicines were recorded using an electronic system on the wards this was not currently possible in the operating theatres.

Staff followed current national practice to check patients had the correct medicines. The trust carried out medicines audits and following the inspection we were provided with documents that evidenced this.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. There was a system in place through the pharmacy to distribute and action national alerts. Local incidents were managed through the trust's incident reporting systems with pharmacy input as needed. We saw examples of good practice; for example, on the thoracic unit we saw a drugs error learning board.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. There were trust policies about this and they were integrated with associated policies such as those covering mental capacity assessments and best interest decisions.

Incidents

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

Staff knew what incidents to report and how to report them and they raised concerns and reported incidents and near misses in line with trust/provider policy. There appeared a culture that incident reporting was normal practice. All staff who we asked talked of incidents they had reported. However, on the Burns Unit one staff member said they didn't report as many as they should although they did not offer an explanation.

Managers shared learning about never events with their staff and across the trust. We were aware of one never event in the inspection window. We saw from submitted documents that there had been a thorough investigation of the incident, that the root causes had been identified and that actions had been carried out and embedded.

Managers shared learning with their staff about never events that happened elsewhere. These were presented and discussed in ward manager's meetings and the lessons were cascaded to staff.

Surgery

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

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. There were systems in place to ensure the duty of candour was followed. We saw evidence that the duty of candour had been followed.

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 and there was evidence that changes had been made as a result of feedback. Both junior and senior staff gave examples which were consistent and clearly demonstrated that the topics had been discussed.

We also noted that several staff talked about serious concerns in the trust's maternity unit and how they had reflected as to whether the issues could be present in their own department or ward. On one ward they said they had changed their documentation practices because of this.

We spoke to a nurse educator who showed how lessons learned from incidents informed the development of her teaching materials as part of the action plan to prevent reoccurrence.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. However, there was a growing backlog of incidents.Learning from serious incidents were displayed on a "learning board". We also understood that while local staff were trained to investigate expert help from outside of the trust would be used if needed.

We noted that one report commented on how the response to the incident resulted in the introduction of additional risks which were themselves addressed.

However, there was a large, and growing number of uninvestigated incidents across the whole of the trust which the trust was aware of and developing an action plan to address. This amounted to 600 across the surgical division.

Managers debriefed and supported staff after any serious incident. Staff told us that they received support both as teams and as individuals.

Safety thermometer

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

The service continually monitored safety performance. Performance dashboards were used to monitor metrics including falls, pressure ulcers and medication safety. Information provided by the service showed overall, all areas which collected this data were achieving the 95% compliance rate. However, the information was only provided to demonstrate overall compliance, we were therefore unable to identify if there were any areas of safety which were not achieving compliance. The service was in the process of introducing the "perfect ward" system of ward audit and although we saw a few baseline assessments this was in its early stages.

Managers regularly reviewed the outcomes from the dashboard at meetings to identify where improvements were required and to also encourage shared learning.

Surgery

Information was displayed at the entrance of wards to give staff, patients and visitors an overview of key safety aspects. Safety crosses were used to display when the ward had last experienced a fall, pressure sore or infection within a given month.

Is the service effective?

Good

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

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We saw patient pathways in place based both on national guidelines and those which were locally developed such as, for example to take patients from other hospitals.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. We did not encounter patients who were subject to the 1983 act, but staff were aware of both the act and the code of practice and the policies that were in place.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. When we discussed individual patients, staff always talked of their and their relatives' emotional needs and were particularly aware of the stresses brought by the restriction of visiting due to the COVID-19 pandemic. They had, for example, introduced recording in the patient's notes of communication between patients and home so as to ensure this was happening and to pick up on any issues.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Patients could choose from a wide range of foods that accommodated clinical needs, religious needs and personal preferences so as to promote eating. Every patient to whom we spoke was complementary about the quality and choice of the food that they were served. Some specialist wards where patients were more likely to have travelled a distance for their treatment provided patients with lunch packs for the journey home.

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. These assessments were updated when needed.

Surgery

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Staff had good access to specialist input including from specialists in swallowing as well as dietitians. We saw examples of where patients had been supported by these professionals and one patient told us their diet had been changed and a dietitian was coming to see them later.

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. Wards had access to a specialist pain team during the day seven days a week including bank holidays. Through information provided by the trust following the inspection it was clear they were proactive in promoting the effective management of pain and they conducted regular audits. They provided training on various aspects of pain management and supported the ward based clinical educators. We saw examples in patients' notes of the involvement of the pain team.

Patients received pain relief soon after requesting it. We saw that following a physiotherapy session a patient said they were in pain and the therapist immediately supplied a cold sleeve before speaking to a nurse. This patient reported that they always got pain relief at a set time before their physiotherapy, so it was working before the treatment started.

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 participated in relevant national clinical audits. Outcomes for patients were largely positive, consistent and met expectations, such as national standards. Managers and staff used the results to improve patients' outcomes. Where there were shortfalls in performance managers took action to improve the standard of treatment.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment.

Managers shared and made sure staff understood information from the audits. Improvement is checked and monitored. In addition to an established "dashboard" the "Perfect Ward" system was in the process of being introduced. We saw it was being implemented and the results displayed and discussed locally. This demonstrated an openness and willingness to use the audit tool.

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 made sure staff received any specialist training for their role. We saw staff competence was assessed. Medical device training

was model based and new equipment was introduced in a managed way to ensure staff were trained before they used it. Because of the COVID-19 pandemic some patients had been nursed on wards of a different specialty to that under which they were admitted. The risks of this were addressed by "outreach" activity by the specialist wards which was often supported by clinical educators.

Managers gave all new staff a full induction tailored to their role before they started work. Induction packages were reviewed when necessary and we discussed an example in urology with a clinical educator. Staff told us that they had access to a secure "what's app" group where questions could be asked and quickly answered, and this was a development that would be kept after the pandemic was over.

Managers supported staff to develop through yearly, constructive appraisals and clinical supervision of their work. Staff told us that they had still received their appraisals and clinical supervision despite the COVID-19 pandemic. Information received following our inspection showed appraisal compliance rates across the surgery division to be 82%.

The clinical educators supported the learning and development needs of staff. Clinical educators were embedded in specialist wards. We saw examples where in response to the changing skills needed on a ward and to incidents packages were developed as part of action plans. We were also told by some staff how clinical educators encouraged them to access mandated training and would cover for them to enable them to attend.

Because of the social distancing requirements of the COVID-19 pandemic face to face team meetings had been suspended. However, managers made sure staff were still engaged and kept up to date. For example, we saw the use of newsletters and video conferencing software. We saw examples of notes which covered local incidents, governance and COVID-19. However, staff were keen that meetings were reintroduced as it was recognised as a more effective way of communicating.

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. Staff were positive about this experience. However, managers said that because of the reduced variety of workload during the COVID-19 pandemic they had concerns that newly qualified staff were not having the opportunity to consolidate their skills, and this was being addressed through personal development reviews.

Managers identified poor staff performance promptly and supported staff to improve. Although we did not see any examples staff told us that poor performance was addressed in a supportive manner.

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 worked across health care disciplines and with other agencies when required to care for patients. Staff were positive about the contribution made by all members of staff and staff who were members of professions allied to medicine told us they felt valued.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We saw examples of MDT meetings convened to address the specific needs of patients. Because of the COVID-19 pandemic meetings sometimes needed to be held "virtually" but we understood they always took place when needed.

Surgery

Staff referred patients for mental health assessments when they showed signs of mental ill health, such as depression. Expert mental health support was usually provided by another NHS trust about which staff were complimentary. We saw examples of local staff who had specialist knowledge being identified and consulted about mental health needs and on the burns unit they had access to their own clinical psychologist.

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. We saw that consultants carried out ward rounds 7 days a week for most surgical specialties and where this was not the case patients were reviewed by suitably senior and experienced doctors.

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

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units. On most of the locations we visited there was material available specific to the speciality as well as more general information, for example addressing diet and smoking cessation. We noted that these were usually only in English, but staff consistently informed us that material in the ten most common languages in the community served were available on the trust's intranet and would be printed for patients who needed them.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Patients were given specific advice on how best to be fit for their surgery and how this would both reduce the risks and aid their recovery and the outcome of their treatment. We saw this described as "fit for surgery". One patient talked of how they had been sent exercise videos to follow prior to their surgery and that they believed the success of their operation was in part due to this.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

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

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records. We noted that consent forms were completed correctly and that these represented good conversations with patients where the risks and benefits of their surgery had been discussed.

Surgery

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. On the pre-operative ward we reviewed the records of a patient with a learning disability we saw that a capacity assessment completed by another organisation had been taken account of and that there was input from the patient's relatives and an Independent Mental Capacity Advocate. The consent had been signed by two doctors as was correct.

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 they knew who to contact for advice. Staff told us they received this training and following the inspection we were sent evidence that this took place as mandatory training.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

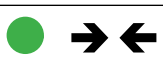
Staff usually implemented Deprivation of Liberty Safeguards in line with approved documentation.

Staff gave good examples including how non-physical coercion not to leave the ward could be restraint. On one ward we saw a good example of a patient who was hallucinating due to their medicines and needed to be dissuaded from leaving the ward. However, staff has discussed with the patient who agreed that they should be prevented from leaving.

However, on another ward a patient had had a DoLS application made despite no Mental Capacity Assessment having taken place. This was because the person making the DoLS application had presumed the requesting doctor would have done so and did not check.

Following our inspection, we requested details of any audits of mental capacity assessments together with any action plans and the trust provided an audit carried out in March 2021 which demonstrated improvements since we last inspected.

Is the service caring?

Good 

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We spent time on wards watching the interactions between staff and patients. Staff ensured that treatment, personal care and private conversation took place behind curtains and moderated their voices to ensure privacy. At other times staff recognised that patients wanted to talk as a group in a bay of beds and responded to that need by joining in and promoting the conversation.

Surgery

Patients said staff treated them well and with kindness. We spoke to 17 patients and almost without exception they said staff treated them with kindness and many were enthusiastic about the care they had received. However, on the thoracic unit two patients told us that the consultant was "rushed" and one commented that they had "no bedside manner".

Staff followed policy to keep patient care and treatment confidential. Staff were discrete when talking to patients about sensitive matters although there were some challenges brought about by the use of masks by both staff and patients. This was particularly problematic when talking to patients who had mild hearing difficulties and to some extent lip read as staff needed to raise their voices.

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. Because patients were more isolated as a result of COVID-19 there was an increased awareness of the mental health needs of patients which was evident in patients' notes. Some patients told us that staff asked about how they were managing without visiting and helped them to express their frustrations and anxieties.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. The trust had access to a chaplaincy service and staff told us they would respond to the varying needs of patients.

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 spoke to 17 patients and some of them gave examples of how they had been supported. One patient told us that they were made to feel at ease, and another explained how staff had recognised how lonely they were and gave them "great" support. Patients were encouraged to keep in contact with home and we saw documentation that staff completed to ensure that patients were keeping in touch with their relatives while they were not able to visit.

We heard of examples where staff had recognised the particular needs of a patient for visiting to take place and it was facilitated in as safe a manner as possible.

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

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. The burns unit had their own clinical psychologist to support patients with the specific challenges of these injuries. We saw one example where a patient was to have a complex and potentially distressing conversation about their treatment options and the staff ensured that their wife was present on the ward for both the benefit of the patient and his spouse.

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.

Surgery

Staff made sure patients and those close to them understood their care and treatment. Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We saw an initiative called “doctor doctor” where patients could complete a form with their questions prior to a ward round so the medical staff could be prepared, and the patients had time to phrase their questions. However, on the thoracic ward one patient told us that they had lots of questions, but the consultant was too busy to answer them during the ward round

Staff supported patients to make informed decisions about their care; in advance where necessary. When reviewing patient notes we saw an example of where a patient had made an advanced decision about the care they wished to receive including not to receive cardiopulmonary resuscitation.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave positive feedback about the service. The primary means of feedback was the “friends and family” test which is an NHS wide programme for hospitals to seek and measure the quality of the care they provide as perceived by the patients. Following our inspection, we requested, and the trust provided the most recent result from this survey for surgery. We noted that the trust’s target for response rate was 30% and the surgical division had a 19% response rate although this was significantly higher than the trust’s overall response rate. The satisfaction ratings, meaning the experience was rated either “good” or “very good” were very high, usually in excess of 97% for the wards at the City Hospital. The lowest score for any ward was 94%.

The service also carried out its own inpatient surveys which covered a variety of factors important to patients. The results were largely positive although there were some low scores for some wards and questions.

Is the service responsive?

Good 

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

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the needs of the local population. At the time of our inspection, due to the COVID-19 pandemic, services had been, and continued to be reconfigured to deal with both the threat of the disease and also to ensure that patients who needed urgent surgery got it in as safe a way as possible. As we inspected the trust was moving its focus to recovering services while still being prepared for future “waves” of the pandemic. This was done alongside the commissioners of services and other providers including those in the independent sector.

One initiative had been to move a significant amount of urgent cancer surgery to three local independent hospitals which meant that the trust had one of the lowest cancer waiting lists. The trust had supported these hospitals with training, provided support and had also supplied their own NHS staff.

The trust had implemented systems to ensure that the service was provided in a manner that minimised the risk of infection during the COVID-19 pandemic. There had been a move to pre-operative assessment taking place “virtually” by telephone or video call to reduce the risk to patients and staff. This had been reviewed and in some places it worked well and was being continued, but in others it was found most patients still needed to attend for tests and so it was stopped.

Surgery

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. No same sex breaches were reported during the year prior to our inspection.

Facilities and premises were appropriate for the services being delivered.There were significant challenges with some of the hospital being more than 120 years old. Some locations contained asbestos and these together with old utilities meant that there were problems with equipment and refurbishment projects were difficult, costly and time consuming. Despite this the trust maintained the provision of services and had a 10-year plan to improve the environment.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems.. Expert mental health support was provided by another NHS trust about which staff were complimentary. However, while there were specialist lead and liaison nurses for patients living with dementia or learning disabilities this was not available 24 hours a day 7 days a week .

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

Managers monitored and took action to minimise missed appointments and ensured that patients who did not attend appointments were contacted. We spoke to staff who were proactive in ensuring that patients attended for both physical and virtual appointments by calling them prior to attendance to ensure they attended.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff also put forward examples of other patients with particular needs and how they had provided care such as those who were prisoners.

There was consideration on the wards for meeting the needs of patients living with dementia within the constraints of the estate. However, the recently introduced perfect ward audit programme specifically addressed the suitability of wards for caring for these patients. While we noted some wards had scored low for some aspects it had prompted improvement plans

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. We saw one that had been prepared while a patient was in the care of another hospital and was being used by staff at the City Hospital to plan the patients care with them and their relatives. The trust provided information from the local carers network about support for people living with dementia, but the figures were not broken down in such a way as to allow conclusions to be drawn for the surgery core service.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff had access to materials and staff with specialist knowledge to support patients with sensory loss or who had difficulty with language. Because of the COVID-19 pandemic and the need to wear masks patients who relied on lip reading were at a disadvantage when staff spoke to them. Staff on some wards, such as the burns unit had access to transparent masks to obviate this problem but on other wards they did not. On Patience 2 ward one patient told us they struggled to hear what was said on ward rounds because the staff wore masks.

The service had information leaflets available in languages spoken by the patients and local community. However, because of the risk of contamination these had to be requested from a member of staff. All the leaflets we saw were in English, but staff told us that they were available in the ten most common languages that people without English as a working language used.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Most patient's needs were identified at outpatient clinics prior to the pre-operative assessments so these would be pre booked. Staff were clear that trust policy was that family members were not used as translators and this was adhered to. The interpreters' diary was available online so should one be needed unexpectedly then it was possible to identify whether a suitable person was onsite. There was also a list of staff who spoke different languages and had volunteered to be contacted should the need arise.

Patients were given a choice of food and drink to meet their cultural and religious preferences. We saw that menus had a range of foods to meet common dietary, cultural and religious needs and staff told us they would try to accommodate individual needs.

Staff had access to communication aids to help patients become partners in their care and treatment. In some locations there were hearing loops to allows people with hearing aids to communicate and portable sets were also available.

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. The COVID-19 pandemic had a significant effect on the surgical activity the service could provide which had an effect on waiting lists. Trust wide, the number of patients who joined the waiting list in the year to April 2021 had increased by 23% compared to the previous year and there was a year on year increase in patients on waiting lists rising from 42,300 to 50,600. Patients waiting more than 52 weeks had risen from 0 to 4,000.

The timeliness of elective surgery had been significantly hindered by the pandemic; however, the trust had followed a similar trend to the England average and was recovering better than the England average from April 2021 onward.

The trust had prioritised the most urgent patients and by working with the independent sector had ensured that the two-week target was met for breast cancer surgery as was that for urgent cancer surgery in urology.

There were regular meetings throughout the day where capacity and flow were discussed and issues escalated. The frequency of these and the seniority of the managers present was dependent on the level of pressure the trust was under. We sat in one such meeting and noted that it was effective.

Managers and staff worked to make sure patients did not stay longer than they needed to. Across all surgical specialities length of stay was comparable to the national average. We noted a higher number for elective orthopaedic surgery at the City Hospital but during our inspection staff raised this with us as an example of a consequence of COVID-19 suggesting that many of the elderly patients had become physically weaker through self-isolation and needed longer in theatre as well as to recover.

Managers made sure they had arrangements for surgical staff to review any surgical patients on non-surgical wards. Managers worked to minimise the number of surgical patients on non-surgical wards.

Surgery

Managers worked to keep the number of cancelled operations to a minimum. When patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. The most common reason was unavailability of beds, usually in intensive care followed by the need to admit an emergency and lists overrunning. This, to some extent, represented the pressures the trust was under during the pandemic. Although figures prior to the pandemic demonstrated that more than 90% of patients were readmitted in line with national targets this data set was currently paused.

Managers monitored that patient moves between wards were kept to a minimum. The service moved patients only when there was a clear medical reason or in their best interest. Under the heightened infection control precautions due to the COVID-19 pandemic ward moves were even more restricted.

Staff did not move patients between wards at night unless there were clear clinical or safety reasons to do so.

Managers and staff worked to make sure that they started discharge planning as early as possible. Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Discharge planning usually started as part of the pre-operative assessment. Where required there was a multi-disciplinary approach and we saw good examples of this in the records. On Harvey 2 ward discharge was nurse led for around half of the patients and this resulted in 60% of their discharges taking place before noon.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. Monitoring of this indicator was suspended across the NHS in 2020 because of the COVID-19 pandemic.

Staff supported patients when they were referred or transferred between services. Managers monitored patient transfers and followed national standards. On the burns unit staff told us that around half of their patients were transferred elsewhere for definitive treatment, but they aimed to get them repatriated back as soon as possible.

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.

The service clearly displayed information about how to raise a concern in patient areas meaning patients, relatives and carers knew how to complain or raise concerns. No patient we spoke to had had cause to make an official complaint, but some told us that they had raised concerns with staff and felt comfortable doing so.

Staff understood the policy on complaints and knew how to handle them. There was information available to help them do so including signposting them to the Patient Advice and Liaison Service. Staff told us that they would always want patients to approach them directly so issues could be resolved quickly for the patient's benefit

Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service. Managers were always able to give examples of recent complaints and were knowledgeable about themes and trends in their area. We also noted that junior staff often talked about similar issues to their managers.

Surgery

On Edward 2 ward a manager said they had had no recent formal complaints but mentioned that noise at night had been a problem and they were addressing it. This correlated with a patient telling us they had mentioned the noise disturbing their sleep and they had been moved to a quieter bed. On the preoperative ward the most common complaint was waiting times although this was usually a discrepancy between the patient's perception of the urgency of their operation and the national targets.

Learning from complaints was fed back to staff both locally and through divisional governance meetings.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We saw example complaints where patients had been kept informed and involved in their complaint and also an example where the duty of candour had been followed.

Staff could give examples of how they used patient feedback to improve daily practice. In the theatre admissions lounge we saw there was an up to date information board that included concerns, complaints and praise. We saw how compliments were also used to reinforce good patient experience and to embed good practice.

Is the service well-led?

Good ↓

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

Leadership

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

Senior staff were clearly knowledgeable about the services for which they were responsible and had the required qualifications and experience. They demonstrated integrity in their dealing with us by the honesty in talking about any problems with the service.

Leaders were very aware of the challenges the organisation had coped with and those yet to come. They had themselves been affected by the COVID-19 pandemic but continued to offer strong leadership.

Staff said leaders at all levels were present on the wards, they were usually able to name them and talked positively of the support they gave. Of the chief nurse one member of staff said it "felt safe" to work under them and another talked about how she took the trouble to give positive feedback to staff. Doctors felt the Medical Director was "supportive" and some foundation year doctors commented that they would like to stay at the trust.

Staff also spoke of numerous instances where senior staff were happy to lend a hand and work on the wards to deal with difficulties or just to be around. The comments staff made about their leaders were notably positive and complimentary. Some staff also talked of managers working for their staff to enable them to deliver care.

Surgery

Vision and Strategy

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

The trust was in the third year of their ten-year strategy which contained promises to patients but they had reviewed and revised it in light of the COVID-19 pandemic. The immediate plans for the following year were largely focussed on a continued recovery to address waiting lists and to be prepared for future "waves" of pandemic illness and winter pressures

Several staff spoke of "TEAM NUH" which had been developed with staff to articulate the organisation's values and to achieve their overall vision to be "Outstanding in health outcomes and patient and staff experience. We heard how "TEAM NUH" stood for:

- Trust
- Empowerment
- Ambition
- Mindfulness
- Nurture
- Unity
- Honesty

This was articulated across the trust trough information for staff and patients and was strongly presented on their website. In discussion with a group of staff on the preoperative ward the inspector was told that the values made them feel "connected".

Culture

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

Almost without exception staff were overwhelmingly positive about how they felt supported, respected and valued by both their line managers and more senior staff. They gave examples of how they had been cared for and how they in turn had cared for one another while they gave support to other areas in the hospital and in some cases across the trust and in other hospitals.

There was a real sense that staff were positive and proud to work in the division and for the trust and morale was high. Despite the challenges staff often said they were happy where they worked and enjoyed what they did.

We saw staff working well together across disciplines, professions and seniority. Staff were complimentary of each other's roles and there were no evident difficulties in working together that would compromise the quality of care.

Surgery

Leaders were aware of how difficult work had been in the pandemic for everyone in the organisation and they recognised that some staff were struggling and had or were at risk of becoming ill. There were various initiatives to support staff under the banner of "well-being" and these included access to enhanced occupational health services and mental health support.

We noted that there was an openness in talking about where things had gone wrong and staff were comfortable discussing incidents and complaints, identifying what had gone wrong and how it was to be fixed. When things did wrong to the extent that a patient suffered harm we saw that there was a supportive approach to finding out what went wrong, addressing the complaint and the "duty of candour" as required by the regulations was followed.

Staff survey results were largely positive and while some elements scored lower than the trust average there was a clear year on year improvement.

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.

At different levels in the organisation there were meetings where there was discussion of key issues such as the results of audits, learning from complaints and incidents and implementation of change which had been such a feature of the previous year. We also saw that these allowed discussion across management groups such as wards, pathways and divisions so that knowledge, experience was shared. Some junior staff mentioned "bottom up" governance from ward managers to matrons and some senior staff told us that the matrons had "the handle" on individual risk.

The social distancing requirements under the COVID-19 pandemic had resulted in many of the meetings being suspended although at a senior level it was still possible to carry them out using collaborative video software.

At a ward level it was not possible to get staff together in one place and the meetings were replaced by newsletters and bulletins. Managers thought that this was not satisfactory, but it was the only option under the circumstances. We saw examples of a number of meetings which the trust sent following the inspection including those the Harm Free Care Committee and notes of ward meetings.

Through their governance processes the senior leadership team had oversight of the management of incidents. Concerns were raised during our inspection about a backlog of incidents waiting investigation and afterwards we asked for more information. There were some 600 incidents outstanding and the rate of occurrence was greater than the rate they were being dealt with.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. However, some low impact risks where not effectively managed.

The risk register was for the whole division and as such it was not possible to identify exactly which risks were associated with the City Hospital. We noted that the top three risks on the register were those that were introduced by the divisional triumvirate during our interview and two of these were relevant to the City Hospital site.

The register described the nature of the risk, its current and target ratings, progress stage and planned and actual review dates. There were 195 risks identified of which 22 were graded as significant or high although again it was not possible to categorically identify whether they affected the City Hospital site. While the highest risks were clearly under review, the top three having been reviewed in the last month others were much older. Seven risks had not been reviewed for more than five years. While the identified risks were "low" or "very" low it was possible that the risk had increased during that time. It was also of concern that nearly all of these risks had a review date that was missed and a target that was met, most of these being pre pandemic.

We understood that there was an initiative to introduce "risk clinics" where staff could drop in and discuss how to address risks. These had been successful at maintaining momentum and we saw evidence that they resulted in ongoing risk reduction.

At a ward and speciality level managers were very aware of the risks in their areas and there was a sense of ownership not just amongst the more senior staff but juniors too who were often well able to discuss risks in their areas. This was aided by the nursing dashboard which was available online to all staff and each month measures 23 metrics. Failure to reach the required target was discussed with staff and the issues addressed. At the time of our inspection the trust was starting to introduce an audit tool called "Perfect Ward". We saw on some wards the first audits had taken place to establish a baseline level of performance. Because of this it was not possible to judge whether it promoted improvement and low scores were not necessarily of concern.

Information Management

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

Where clinical data was needed for, for example for national clinical audits, clinical staff told us they had the administrative support to ensure it did not impact on their time to deliver care.

Senior leaders told us of their ambition to get the electronic prescription of medicines in place as it was currently all on paper in the operating theatres. There were also risks associated with the trust's Picture Archiving and Communication System (PACS) because of the design of the underlying network. Because of the age of the estate there were constraints in providing a comprehensive Wi-Fi network on the City Hospital site.

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.

There was a clear culture of improvement embedded in the division with staff at all levels keen to be involved in improvement and innovation and this was encouraged by leaders.

Staff were proud of what they did and we heard of several initiatives. On the Preoperative ward staff were proud that one of their band 6 nurses sat on a NICE guidelines board. They also told us that the "shoulder team" had developed a local pathway for shoulder replacement that was being considered for adoption nationally.

Surgery

The thoracic ward had introduced a system where porters were trained to take patients with a chest drain to x-ray without an escort freeing up staff time and they had also setup a self-referral chest drain clinic which reduced admissions and complications.

Conversely some staff mentioned that the low turnover of staff on individual wards sometimes had the effect of stifling new ideas and that there were sometimes not enough fresh eyes.

Queen's Medical Centre

Derby Road
Nottingham
NG7 2UH
Tel: 01159249944
www.nuh.nhs.uk

Description of this hospital

Nottingham University Hospitals NHS Trust provides a range of elective and emergency surgery at Queen's Medical Centre. The surgical core service spans across five divisions at the trust including surgery, medicine, clinical support, ambulatory care and cancer and associated specialities. Surgical specialities at this location include neurology and neurosurgery, spinal surgery, ophthalmic surgery, orthopaedic surgery, colorectal surgery, general surgery, hepato-pancreatico-biliary surgery, vascular surgery and ear nose and throat surgery. There are 337 beds for surgical patients including both inpatient and day case surgery. There are 36 operating theatres at this location.

During our inspection we visited eight wards (C31, C32, D10, E14, E15, E16, F18 and F19), pre-operative assessment, theatres, recovery and the post anaesthesia care unit (PACU). We spoke with 12 patients and one relative and 44 members of staff. These included service leads, matrons, nurses, consultant surgeons and anaesthetists, junior doctors, therapists and healthcare assistants. We observed care and treatment and looked at 24 complete patient records.

We carried out an unannounced focused inspection of the emergency department at Queens Medical Centre on 14 July 2021 as part of our on-going regulatory oversight of the trust. We used our focused pressure resilience inspection methodology and did not explore all key lines of enquiry.

The emergency department (ED) at the Queens Medical Centre (QMC) is open 24 hours a day seven days a week and is a designated major trauma centre. It sees approximately 650 patients per day and includes a paediatric emergency department dealing with all emergency attendances under the age of 18 years.

Patients present to the department either by walking into the reception area or arrive by ambulance via a dedicated ambulance-only entrance. The department has different areas where patients are treated depending on their needs, including a resuscitation area; a 30 bed majors area with an additional six cubicles used during periods of escalation; 20 bed clinical decision unit; urgent treatment centre which was operated by a third party but was co-located at the main reception area of the ED; a Covid-19 isolation area; and a separate paediatric ED with its own waiting area and treatment cubicles within the department.

We looked at all areas of the department and we observed care and treatment. We looked at 15 sets of patient records. We spoke with 19 members of staff, including nurses, doctors, allied health professionals, managers, support staff and ambulance crews. We also spoke with six patients who were using the service at the time of our inspection. We reviewed and used information provided by the organisation in making our decisions about the service.

Surgery

Good

Is the service safe?

Good

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

Mandatory training

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

Not all staff were up-to-date with their mandatory training. Managers told us the pandemic had impacted upon mandatory training and sessions were suspended during the peak of the COVID-19 pandemic. Information received after the inspection showed compliance with mandatory training for the whole of the service was 75%. This falls below the trust target of 90% however, there were comprehensive recovery plans in place with projections for how compliance will improve against this plan. It is estimated that this recovery plan will achieve the trust target by March 2022.

The mandatory training was comprehensive and met the needs of patients and staff. Training was conducted through electronic learning systems and through face-to-face (socially distanced) teaching sessions. Staff also told us they were looking to introduce scenario-based training for more subjects where possible due to the positive feedback these sessions usually received.

Staff completed training on recognising and responding to patients with mental health needs and patients living with dementia. However, there was currently no formal training for staff on learning disabilities and autism. Information from the trust indicated the learning disability team would be reviewing this imminently, however as autism was such wide spectrum, it was unlikely any such training would include this.

All staff were required to complete adult basic life support. Information requested from the service showed only 53% of staff were compliant with this training requirement against a trust target of 90%. The recovery plan in place identified a requirement to increase this compliance due to the importance of staff possessing up-to-date skills. Additional trainers were being identified for all areas to help increase the training opportunities and raise compliance. However, access to and the roll out of, resuscitation training was limited during the pandemic as the trainers were redeployed into critical care areas. Staff told us no additional life support training such as immediate life support training, was available to them. This was despite some staff identifying this as a desirable course to help upskill them within some areas where they worked, and where the acuity of the patients had increased.

Managers monitored mandatory training and alerted staff when they needed to update their training. We also found clinical educators completed this role to support ward managers in some areas.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Training had been affected by the COVID-19 pandemic and a programme to catch up was in place. At the time of our inspection the service had an overall

60% compliance with safeguarding training. Safeguarding adults' level one and safeguarding children level one had the higher compliance among staff of 84-85%. These modules were completed every three years by staff. Safeguarding adults' level two, safeguarding children level two and safeguarding children level three had a recorded compliance of 68%. These modules were required to be completed on an annual basis. Staff told us the training they received gave them the confidence and knowledge about safeguarding and recognising and reporting abuse.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Without exception, all staff spoke confidently about how they protect all patients under their care from harassment, discrimination and abuse.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff spoke of a good relationship with external agencies when reporting concerns to them. Some staff were able to provide examples of when they had escalated concerns and the ways in which teams worked together to protect patients (and children in one example) from avoidable harm and abuse.

All staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us they were confident in the reporting processes of a safeguarding concern. If staff had any questions about safeguarding, they would discuss with their manager or the trust safeguarding team who were very accessible and supportive.

Prior to the pandemic, staff followed safe procedures for children visiting the ward. However, visiting of ward areas was still restricted at the time of our inspection. Staff told us of aspects to be aware of though if children were visiting and one staff member provided an example of how they had escalated concerns.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained. All staff commented on the age of the building and the challenges this had presented in some areas (ventilation was one main challenge identified during the COVID-19 pandemic) but this did not impact on the cleanliness or maintenance of the wards and theatre areas.

Staff told us they generally performed well for cleanliness on their audits. Information received after the inspection showed all areas which were included in the surgical core service achieved above 90% for their cleanliness metric on the dashboard. The average compliance across all areas was 97% for cleanliness.

Staff followed infection control principles including the use of personal protective equipment (PPE). All offices and communal areas had been risk assessed and a limit on the number of people allowed in the area was clearly identified. We observed these limits were mostly adhered to with staff highlighting any concerns with their colleagues if the limit was breached.

We observed staff demonstrating good hand hygiene measures in accordance with the World Health Organisations (WHO) five moments for hand hygiene.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We reviewed a selection of items including commodes, clinical observation and resuscitation equipment and found them to be clean as

stated on the 'I am clean' label. During our inspection we observed signs for regular cleaning opportunities throughout the day which were due to take place at 10am, 2pm and 6pm. However, during our period of inspection on ward E15, this did not appear to take place at 2pm. Some staff told us this did not always happen anymore. During the pandemic, this was a regular occurrence, however this had recently become less frequent.

Staff worked effectively to prevent, identify and treat surgical site infections. There were procedures in place to reduce the risk and monitor for signs of surgical site infections (SSI) in line with NICE CG 74 Surgical site infections: prevention and treatment. All SSIs were investigated and discussed at divisional meetings. Specific bundles were in place for the prevention of SSIs within vascular and spinal surgeries.

Staff completed screening for MRSA (Meticillin, resistant *Staphylococcus aureus*), *Clostridioides difficile* (*C. difficile*) and Carbapenem resistant enterococci (CRE) during the pre-assessment appointment prior to surgery. Patients who received a positive result then had an IPC plan put in place for them depending on the organism they were positive for. In the period of April 2020 to March 2021, the service recorded 227 bacteraemias (blood stream infections) of which 72 were related to intravenous lines. This included two cases of MRSA bacteraemia, 29 MSSA (Meticillin sensitive *Staphylococcus aureus*) bacteraemia's, 46 *Escherichia coli* (*E. coli*) bacteraemia's. Within the same time period, the trust also recorded 33 new MRSA acquisitions (patients who tested/screened positive for MRSA for the first time) and 119 cases of *C. difficile* which were trust apportioned. The trust also recorded 16 cases of CRE, however these were not broken down into speciality/ward areas.

The trust had implemented a 'purple pathway' for patients who were admitted for elective procedures. These patients had completed a required amount of isolation in addition to taking COVID-19 tests prior to admission. For those patients who had not been able to complete a period of isolation prior to admission (but had tested negative) they were admitted under the green pathway. Staff told us this was an additional step taken to try and ensure patients were kept safe from the risk of infection. Since implementation of the purple pathway, there had been no incidents of patients becoming symptomatic whilst admitted on the ward. National guidance recommends all vulnerable patients to consider isolating/shielding for 14 days prior to an elective admission as part of the low risk (green) pathway.

Patients who were confirmed or suspected of having an infection were isolated where possible and a sign placed on the door to advise staff of what precautions were required. There were three different signs for staff to display, depending on the infection the patient was confirmed or suspected of having. Yellow signs identified wound and skin infections, brown identified enteric infections and green identified respiratory infections. Where source isolation wasn't appropriate or could not be provided, patients were cohorted in bays, as seen during the COVID-19 pandemic.

We did not observe any signage at entrances of wards to indicate the level of risk for COVID-19 and the PPE staff and visitors were required to wear. National guidance recommends clear signage be utilised to reduce the risk of mixing pathways and reduce the flow of staff. This was also advised as part of NHS England, infection prevention and control board assurance framework. However, on ward E14 which was a purple ward, we found staff access had been restricted to reduce the flow of staff and protect the patients admitted on there.

Environment and equipment

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

Patients could reach call bells and staff responded quickly when called. We did not observe any patients who did not have their call bell to hand during our inspection. During our inspection, we heard staff testing out the alarm system to ensure this was in working order.

Surgery

The design of the environment did not always follow national guidance. Staff referred to the age of the building and the inability to complete major changes to meet the current needs of the patients being admitted. In some areas, isolation facilities were few which impacted on staff being able to safely isolate patients who were suspected or confirmed of having an infection. We were also told there had been challenges with the ventilation of the areas which had come to light during the recent COVID-19 pandemic. We identified designated handwashing sinks within clinical environments which did not meet the health building note (HBN) 00-09 infection control in the built environment due to overflows being present.

Staff carried out daily safety checks of specialist equipment. We found resuscitation equipment, fire extinguishers and airway equipment were checked daily and this was recorded. All areas had an additional bag of equipment attached to the resuscitation trolleys for cardiac arrests during the COVID-19 pandemic. These were also checked daily along with the main resuscitation trolley.

The service had suitable facilities to meet the needs of patients' families. However, at the time of our inspection, visiting was restricted so there was little requirement for families to utilise the facilities.

The service had enough suitable equipment to help them to safely care for patients. However, some staff did acknowledge information technology (IT) equipment was low in some areas which impacted on their ability to record information or review information on the intranet at times.

We reviewed 34 pieces of equipment during our inspection across surgical wards and theatres and found all items had evidence of electrical safety testing and in-date servicing. We also reviewed a selection of consumable items (syringes, blood bottles, dressings) and found items were in date.

Staff disposed of clinical waste safely. We observed staff correctly segregating clinical and domestic waste. Waste bins were enclosed and foot operated. Sharps bins were correctly assembled and below the fill line, however the temporary closure mechanism was not always used. The management and disposal of sharps and waste was completed in accordance with policy.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used the National Early Warning Score (NEWS2) when performing observations. Observations were recorded on an electronic system which automatically alerted staff when a patient was scoring four or more. Some staff told us they would also communicate with the doctors if they had a patient who was scoring high on the NEWS2 to ensure responsive action was taken. We saw evidence of staff documenting when a patient had been reviewed following a high NEWS2 score with a clear plan of care and treatment evident.

Staff had access to a critical care outreach team for patients who were identified as deteriorating. Staff told us they usually requested their assistance for patients who had a NEWS2 score of seven or above.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. All risk assessments were completed on the electronic system on admission and had weekly reviews to ensure the information was still correct. In the case of an incident occurring (for example a fall) a new risk assessment was completed to reflect the patient's situation. Out of 24 records, we did not identify any risk

assessments that were either not completed or overdue a review. However, audit information received after the inspection showed staff did not always complete timely VTE (venous thromboembolism) risk assessments. Audit information showed the service had continued to fall below the 95% target between December 2020 to June 2021. An action plan on how to improve compliance with VTE risk assessments was in place and managers closely monitored improvements.

Staff knew about and dealt with any specific risk issues. The service had seen a rise in the number of incidents as a result of pressure related damage to patients and had therefore increased staff awareness on the requirements for ongoing reviews of patients. We observed staff completing SSKIN inspections on patients to identify any early signs of pressure damage. The timing of these reviews was tailored to patient specific needs (ranging from hourly to four hourly depending on the level of activity a patient undertook, and risk identified on the pressure area risk assessment).

Staff in all areas spoke confidently about the identification and management of sepsis within patients. Staff told us the electronic observation system used would prompt staff to consider sepsis screening when a patients NEWS2 was out of acceptable range for that patient. However, we observed a patient with a NEWS2 score of nine who although had been reviewed appropriately and timely, there appeared to be no consideration for the possibility of sepsis developing and no sepsis screen had been completed. We asked senior members of the division about this during our inspection who told us they would expect medical staff to complete a sepsis screen on patients in this situation. A report provided after the inspection showed staff responded to this prompt over 85% of the time within the 60 minute period where action is considered essential to improve the outcome for the patient, with just above 75% being within 20 minutes of the prompt being provided on the electronic system.

Further information requested from the trust showed 47% of patients considered high risk sepsis between 1 April 2020 and 31 March 2021 received the full sepsis bundle in the required timeframes. This fell below the trusts own target of 70%.

Sepsis training for the surgery division was recorded as 52% compliant at the end of March 2021. The information did however identify staff had experienced some challenges with accessing the training on the electronic system which may have impacted staff compliance.

We observed good practice in relation to carrying out essential safety checks prior to patients undergoing their procedure. Staff used the WHO safer surgery checklist to ensure it was safe to proceed through each stage of the operation and all staff engaged. We reviewed six WHO checklists and found all were completed comprehensively. Completion of the WHO checklist was a metric on the dashboard which teams had a constant oversight of. Compliance with the completion of these checklists was documented between 90-100%.

The service had 24-hour access to mental health liaison and specialist mental health support. This included the arrangement of psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff spoke highly of the service and their quick response when advice and support was required.

Staff shared key information to keep patients safe when handing over their care to others. Staff used handover sheets to record essential information to hand over to the next staff looking after the patients. Staff also ensured any changes which occurred during the shift were communicated with the nurse in charge and other relevant staff to ensure patients were kept safe.

Surgery

Nurse staffing

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

Staff told us the service had enough nursing and support staff to keep patients safe. Managers told us there had been an increase in recruitment which had reduced the overall vacancies. We asked for information on staffing for the service including the number of staff that should be on each ward or department against the number of staff in post. We did not receive this information from the service.

Following concerns raised to us by staff about the surgical triage unit (STU), we requested further information on staffing requirements for this area. Information received showed their actual staffing did not always meet the planned staffing (band five nurse positions were usually underfilled by two members of staff for both day and night shifts. STU and the adjacent ward had one single cost centre/overall budget which was divided across the two areas. This meant the staffing establishment was managed across the two areas on a day to day basis. Therefore, staff from the adjacent ward (and sometimes agency) were utilised to fill staffing shortfalls on STU. Due to an increase of establishment for STU, there was currently a recruitment programme in place.

The ward manager could adjust staffing levels daily according to the needs of patients. Where additional staff were required due to an increase in acuity or specific needs of patients, staff told us this would be done.

The number of nurses and healthcare assistants matched the planned numbers. Most areas we visited clearly displayed this information and we found planned staffing matched the actual staffing.

Staff told us the service had low turnover rates. In areas where staff had left, they had left due to promotions or for career opportunities. On ward D10, staff told us they had lost staff, but this was due to staff accessing training courses for other roles. One member of staff had left the ward to commence their medical course.

The service had an average sickness rate of 4.1% between July 2020 to May 2021 for registered nurses. Information received after the inspection showed there was a spike in sickness between December 2020 to February 2021, which coincided with the second wave of the pandemic. This supported what staff in the clinical areas told us about staff sickness. Most staff told us sickness rates were reducing now, although managers were aware of the potential for an increase over the next few months due to burn out or mental ill health as a result of the pandemic.

From the information we received, it was not clear which staff group the healthcare assistants were allocated to so were unable to extract sickness data for them.

Staff told us they limited their use of bank and agency staff and requested staff familiar with the service. Where staff from agency or the bank were used, they were required to complete a local induction to familiarise themselves. Information received after the inspection showed general surgery had the highest usage of locum/agency/bank staff, however the information did not identify staff groups, so we were unable to confirm this was specifically related to nursing staff and healthcare assistants.

Medical staffing

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

Surgery

Staff told us there were enough medical staff to keep patients safe and that vacancy rates were low. During our inspection we observed good numbers of staffing and rotas were well staffed. We requested information on the number of medical staff which should be in post against actual numbers in post, however we did not receive this information.

The service had low and/ or reducing turnover rates for medical staff. Staff told us they enjoyed working within the service at this location and there was a low turnover rate. Some junior staff told us they hoped to gain employment with the service when they progress to the next role.

The service had an average sickness rate of 1% between July 2020 to May 2021 for medical staff. Information received after the inspection showed sickness rates for medical staff was relatively low compared to other staff groups throughout the duration of this period. The highest rate of sickness was July 2020 when it reached 1.4%.

Staff told us the service had low rates of bank and locum staff. Information received after the inspection showed general surgery had the highest usage of locum/agency/bank staff, however the information did not identify staff groups, so we were unable to confirm this was specifically related to medical staff.

Managers could access locums when they needed additional medical staff and 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. All staff we spoke with told us there was a good mix of skill within their teams.

The service always had a consultant on call during evenings and weekends. Staff told us there were two consultants on call out of hours for general surgery, neurosurgery and trauma providing first and second on call.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. However, we found records were not stored securely.

Patient notes were comprehensive and all staff could access them easily. We reviewed 24 complete sets of notes and found entries were not only comprehensive but legible, signed and dated and met the standards set by the professional bodies. However, we found that although care plans were in place for all patients, not all care plans were individualised to the patient. Care plans were pre-printed to ensure the basic requirements were covered, however there were options for staff to individualise them to the patient's requirements. An example of one which we saw individualised to the patient was for their NEWS2 requirements. The care plan had documented on it what was considered their acceptable range before escalation was required.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff told us they had access to patient records in a timely manner when patients transferred into their services.

Medical records were stored in trolley's outside of the bay areas where patients were cared for. These were not locked and could be accessed by anyone within the ward area. However, staff were observed to be in the areas where records were stored and would challenge anyone who they thought should not be accessing records. Staff on one ward challenged inspectors whilst reviewing notes to ensure they were authorised to review them. Nursing records were stored on the nurse's desk outside of the bay.

Surgery

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. We reviewed the storing of controlled drugs and found these to be stored correctly and accurately. We did however find that on one ward the room temperature for where medicines were stored had been out of range for several days however despite escalating in accordance with trust policy, no action had been taken.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Wards and departments had their own pharmacy staff attached to their areas who reviewed patients' medicines and provided advice for the staff if required. Pharmacy staff also ensured all medication charts had the patient's allergies and weight documented.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. We reviewed 24 medication charts and found staff prescribed medicines correctly and safely, including as required medicines. When staff did not administer medicines, codes were used to indicate this with further explanation at the rear of the document. We did not observe any medicines left on patient bed tables.

Antimicrobials were prescribed according to best practice with a stop or review date being indicated and all prescriptions had an indication documented. The medication chart had been created to aide correct antimicrobial prescribing by having an area for antimicrobials to be prescribed when infection was suspected. The area automatically prompted staff to review the prescription after three days. There was also an area for antimicrobials to be prescribed once infection was confirmed.

Staff followed current national practice to check patients had the correct medicines. We observed two staff members attending a patient who was due to have a controlled medicine. All patients receiving medicines had their name bands checked as well as a verbal check for allergies in line with trust guidance.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Safety alerts were managed centrally by the trusts pharmacy teams and cascaded to areas through pharmacy staff attached to the ward/department areas.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. We did not see any evidence of medicines being used to control patient behaviour during our inspection. However, staff were aware of trust policies guiding staff on the use of this process and would also seek advice from the mental health team if this was required.

The service participated in surveys and audits to ensure staff medicines were administered safely and effectively. The most current survey conducted was on critical medications and the knowledge staff had around these. This was linked with the omitted doses work which was in progress due to evidence of critical medicines being needlessly omitted. Unfortunately, the audits which were planned to gain further insight into this had been delayed due to the COVID-19 pandemic. Results of the survey did not break down the results into divisions or wards, however the results showed there was variable knowledge around critical medications.

Surgery

Incidents

Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored. However, we found there was a backlog of incidents which were yet to be investigated.

Staff knew what incidents to report and how to report them.Staff raised concerns and reported incidents and near misses in line with trust policy. Without exception, all staff told us they reported incidents and near misses. The most common incident reported within all surgical wards were pressure area related. Information relating to surgical services incidents showed there were 1366 incidents reported between 1 November 2020 and 30 April 2021 with a large proportion of these being reported as no harm (948 incidents). These incidents covered the service as a whole and were not broken down into the two hospital locations.

The service reported one never event with two additional never events involving the theatre department but attributed to different services. Despite two of the never events being attributed to other services, there were similarities within the themes of the three never events as they all involved the retention of foreign objects.

Managers shared learning about never events with their staff and across the trust as well as sharing learning with their staff about never events that happened elsewhere. Managers also looked at other trusts where never events occurred to bring the learning from them into the service. Managers told us following the incident involving a retained guide wire which was attributed to a different service, they identified there had been three other similar incidents which they could have learnt from, however they ensured their learning was widely distributed and immediate action was taken internally. At the time of our inspection, the most recent never event which was attributed to the surgical service was still under investigation.

Staff reported serious incidents clearly and in line with trust policy. There were 21 serious incidents reported under the STEIS (strategic executive information system) framework for the service at this location between 1 April 2020 to 31 March 2021. Most of these incidents (16 incidents) were related to pressure ulcers meeting the serious incident criteria.

Most 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 were familiar with the duty of candour and the concept of being open and transparent when things went wrong. Most senior staff were able to describe the process for undertaking, and when to formally undertake the duty of candour. We did however identify confusion amongst some staff when discussing duty of candour, specifically around incident investigation. There was a trust policy in place which directed staff as to when to implement duty of candour and how this should be completed formally which all staff were aware of.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us on all wards what their last incident/serious incident was which they had to investigate and were able to provide examples of learning identified.

Senior staff met to discuss the feedback and look at improvements to patient care. Information from these meetings was distributed to other staff through ward or department communications (newsletters, emails or social media groups).

Despite staff being able to recall most recent incidents and the learning from them, not all staff were able to evidence that changes had been made as a result of feedback. All staff were aware of the current increase in pressure damage

related incidents, however the service was still in the process of identifying a plan for ensuring long term improvements were made in the management of patients who were assessed as being at risk of developing a pressure sore. The service did have rapid learning events (RLEs) in place for any pressure damage related incidents where immediate learning and change could occur if evident.

Staff in theatres were able to evidence changes that had occurred due to a serious incident. This involved a procedural change for the insertion of a shunt. The process now ensured a safer approach to the insertion with the use of ultrasound guidance.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. However, we found there was a growing backlog of incidents which had yet to be reviewed and investigated.We reviewed three serious incident reports involving surgical services at the trust and found these had been fully investigated and looked at the causes of the incident. They identified learning opportunities and had action plans in place with staff members identified as the lead for each action. There was evidence of duty of candour being implemented with an invitation to meet with the investigating panel to discuss the outcomes of the report. When an incident of medium harm or above was identified, these went through a review process called surgery incident review forum where immediate learning was established and shared.

Within the divisions which made up the surgical core service, there was 808 incidents which were open and overdue. These incidents had yet to have any review or investigation and the risk within them was unknown. Information provided after the inspection was noted to be a wider concern than just this service and the trust as a whole were proposing to change how they managed incidents and had a plan in place to manage the backlog of incidents which were growing.

Managers told us they debriefed and supported staff after any serious incident. However, staff were unable to discuss times when this had occurred. This was due to the nature of the serious incidents reported. They felt confident if the incidents were of a more upsetting nature, mangers would provide debriefing sessions. It was added that when anything on the wards occurred which was upsetting or stressful, managers would always check on staff to ensure they were ok.

Safety thermometer

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

The service continually monitored safety performance. Dashboards were used to monitor 23 metrics including falls, pressure ulcers and medication safety. Information provided by the service showed all areas which collected this data were achieving the 90% compliance rate. Information received following the inspection showed the majority of the metrics were individually above compliance rate. However, we did observe some areas which fell bellow. Nutrition within the surgery division recorded an 85% compliance rate and ambulatory care had three areas below compliance (medicine- 85%, nutrition- 75% and pressure ulcers- 85%).

Staff used the dashboard data to further improve services. Managers regularly reviewed the outcomes from the dashboard at meetings to identify where improvements were required and to also encourage shared learning.

Information was displayed at the entrance of wards to give staff, patients and visitors an overview of key safety aspects. Safety crosses were used to display when the ward had last experienced a fall, pressure sore or infection within a given month.

Surgery

Is the service effective?

Requires Improvement

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff delivered high quality care and treatment in line with, in date policies, procedures and guidelines which were based on best practice and national guidance and policies. Staff assessed patients' needs and planned and delivered care in line with National Institute for Health and Care Excellence (NICE), the Royal College of Surgeons and the Association of Anaesthetists. Examples of guidance which had been implemented by the service was CG (clinical guidelines) 103 delirium: prevention, diagnosis and management, NG (NICE guidance) 45 preoperative tests and CG24 hip fracture and elective hips and knees.

Across the service, we saw evidence of staff following NICE clinical guidelines CG92 in the assessment and treatment of venous thromboembolism (VTE). VTE is the formation of blood clots in the vein. All patients were risk assessed on admission and appropriate treatment prescribed by medical staff if deemed at risk.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. At the time of our inspection, there were no patients who were subject to the Mental Health Act. However, staff were aware of the Act and would follow the Code of Practice.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Staff regularly considered the psychological and emotional needs of their patients. Staff told us the COVID-19 pandemic had impacted upon their patients considerably and was an essential area of their holistic care. Staff had implemented a communication sheet for relatives of their patients to demonstrate regular communication, but also to capture the concerns and needs of the relatives.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff assessed patients for pain during routine observation times using a numerical scoring tool or a pictorial chart for patients who were unable to verbally communicate. Staff told us they also wrote down questions for patients who had hearing impairments to gauge the information required. This was then recorded on the observational tool in use.

Patients received pain relief soon after requesting it. We observed staff asking patients about their pain and responding in a timely manner with medication.

Staff prescribed, administered and recorded pain relief accurately. Patients who returned from theatre had a range of analgesic (pain relieving) medicines prescribed for them which staff would administer. Some patients had continuous pain relief in place through an epidural or patient controlled analgesia system. Staff were required to undertake additional training to enable them to care safely and effectively for patients with these types of systems in place. The pain specialist would also support patients who had these systems in place and would advise the team when to consider switching the patient to oral analgesia. Additionally, the pain specialist would also provide support and advice to patients experiencing moderate to severe pain.

Patient outcomes

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

The service participated in relevant national clinical audits. This meant outcomes of care and patient mortality could be benchmarked against similar units nationwide.

Outcomes for patients were mixed for this location, however where standards had not been met, there was evidence of some improvement.

- National Emergency Laparotomy Audit (NELA): Results from the most recent audit showed the service was performing worse than the national average for;
- Crude proportion of cases with pre-operative documentation of risk of death (73%).
- Crude proportion of high-risk cases (greater than or equal to 5% predicted mortality) with consultant surgeon and anaesthetist present in theatre (65%). Although this was recorded to be below the national standard, the service at this location had seen an improvement from the 56% which was recorded in the previous audit.
- The proportion of patients who died within 30 days of admission (adjusted for the case-mix of patients seen by the provider) was recorded as 6% which was an improvement from the 10% in the previous audit.

Staff told us the NELA audit was an ongoing process where feedback on potential improvements is received after each quarterly submission. The most recent submission for quarter three 2020/21 is due to be published soon, and this will show an improvement in some measures, however there were still areas for further improvement to be made in relation to consultant presence in theatre for high risk cases. Some concerns were noted by staff around the coding for this measure. On occasions, consultants had been present in theatre however they were completing other roles at the time, but this was not necessarily considered. Also, anaesthetic staff told us there had been times where consultant anaesthetists were not requested to theatre for these cases due to the competency of the anaesthetist at the time (who was due to take up a consultant post imminently).

- National Hip Fracture Audit: Results from the most recent audit showed;
- The service at this location performed similar to other trusts for overall length of stay, the percentage of patients receiving surgery on the day of or day after admission and perioperative medical assessment.
- The service at this location performed better than similar trusts for patients that were documented not to have developed a pressure ulcer.

Staff also told us they contribute to other national audits, an example being the NAP seven (national audit programme) audit on perioperative cardiac arrest.

Managers and staff used the results to improve patients' outcomes. Information shared by the service showed audit outcomes and research conducted locally fed back into pathways to improve the patient experience and overall outcomes.

The service had a higher than expected risk of readmission for elective care than the England average between January and December 2020. Neurosurgery and ophthalmology had the highest risk of readmission at this location.

The service had a slightly higher than expected risk of readmission for non-elective care than the England average between January and December 2020. Spinal surgery services demonstrated the highest risk of readmission at this location. However, non-elective trauma and orthopaedics had a lower than expected risk of readmission between this period.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time. At the time of inspection, there was an open outlier alert for the service in relation to therapeutic endoscopic procedures of the biliary tract. Information received after the inspection showed staff had completed a comprehensive review of the data for this outlier measure and found two cases which had been included were classified incorrectly. Following the exclusion of these two patients, the mortality rate was 1.5% which was below the national average of 1.7%. Further review of the nine patients who had died following ERCP (Endoscopic Retrograde Cholangio-pancreatography) identified there were three patients who had died of known complications of ERCP. As a result of the review conducted, staff identified learning around the suitability of patients selected to undergo the procedure.

Managers shared and made sure staff understood information from the audits. Audits and quality improvement projects and associated outcomes were a regular discussion topic at meetings. Through discussion with all staff, additional measures to those proposed by the audit reports were sometimes suggested and implemented to improve outcomes for patients.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment. Improvement is checked and monitored. All staff understood the audit process. Audits were scheduled for repeat after time was given for improvement measures to be embedded. Staff told us ‘Perfect Ward’ had recently been introduced which was centred around a variety of audits which were conducted on a weekly or monthly basis to demonstrate where improvements had been made or where more attention was required.

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. Where applicable, managers made sure staff received any specialist training for their role. Within many areas, staff completed specific competency packages to ensure they had the right skills to support patients. On E14, they had created eight level one beds (for patients who were at risk of deteriorating or stepped down from a higher level of care). These beds were for patients who were post-operative from significant surgery and required closer monitoring due to risk of deterioration. The additional competencies gave staff the confidence in caring for these patients independently. A competency package had also been created on D10 for the staff caring for patients who had neurological surgery.

Surgery

Managers gave all new staff a full induction tailored to their role before they started work. Staff told us the trust induction and local inductions were comprehensive and met their needs to start work safely.

Managers supported staff to develop through yearly, constructive appraisals of their work. Most staff told us they had continued to have their appraisals despite the challenges encountered due to the pandemic. We requested information following the inspection on the numbers of staff who had received their appraisal; however, this was not shared with us.

Not all staff were supported to develop through regular, constructive clinical supervision of their work. Where staff told us, they had received clinical supervision, this was not always constructive and did not always help them to develop.

The clinical educators supported the learning and development needs of staff. Most of the ward areas we visited had access to clinical educators who were attached to their areas. Staff were complimentary about the value of the clinical educators, especially in areas where competency packages had been established for staff.

Team meetings had been suspended during the COVID-19 pandemic. However, managers produced newsletters to keep staff up to date. In addition to the newsletter, some areas had closed social media groups where updates could be shared confidentially. Managers told us in some wards they were intending to start physical team meetings again soon in line with on-going restrictions.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us they felt supported by their managers to develop their skills further. On one ward, staff told us how they had supported their colleagues to progress in their careers by completing training for nurse apprentices, nurse training, paramedic training and one staff member had started their medical training.

Managers identified poor staff performance promptly and supported staff to improve. When concerns were identified in a staff members performance, this was responded to quickly and appropriately and personal action plans were implemented to help with the staff members development.

Multidisciplinary working

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

The multidisciplinary team consisted of doctors, nurses, healthcare assistants, physiotherapists, pharmacists, microbiologists, dietitians, specialist nurses (including pain, learning disability, tissue viability). All members of the team worked well together to ensure the best outcome for the patient. All staff spoke positively about the support they received from the wider MDT.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Members of the multidisciplinary team (MDT) were encouraged to attend ward rounds to discuss patient plans. Additional MDT meetings were arranged if a patient was a complex case and additional members of the wider MDT team (for example, social workers, independent mental capacity advocates (IMCAs), specialist surgeons etc.) were required to attend. Staff told us some of these meetings had taken place using video conferencing calls which had improved attendance in some cases to the meetings.

Surgery

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff were able to refer to examples of when other agencies had been contacted to contribute to the plan of care for patients. Within the orthopaedic wards, orthogeriatric teams supported staff to complete assessments of patients admitted within the speciality.

Staff referred patients for mental health assessments when they showed signs of mental ill health. Staff were complimentary about the mental health support they received for their patients from the trust who provided this support. Within some wards, staff told us there were staff members who had a mental health and learning disability background and were able to support others with determining what additional support patients required who showed signs of mental ill health.

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. No concerns were raised by staff over the ability to access consultant level care if this was required.

Planned surgery was usually performed Monday to Friday, however since the COVID-19 pandemic, consultants had been adding additional lists on occasions on the weekends as part of the planned recovery of elective patients.

The surgical triage unit on C32 was open 24 hours a day, seven days a week. Consultant presence on this area was increased due to the nature of the admissions and potential for escalation of care. Emergency surgery was performed when required and medical rotas enabled this. Emergency theatres were staffed to enable two theatres to run at the same time, with an additional neurosurgery emergency theatre if required. Emergency paediatric surgery was usually covered by the children's and young people's service, however if a general surgeon was already on site, staff told us they would attend and perform the surgery if within their capability.

Staff could call for support from doctors and other disciplines, including (but not limited to) mental health services and diagnostic tests, 24 hours a day, seven days a week. In addition to this, there was pharmacy cover out of hours and allied health professionals were also available during weekends and through an on-call system out of hours.

Staff told us there was a hospital at night team that could be called for help and support between 8pm and 8am, seven days a week. This team provided the staff with support with a range of tasks and physical support in the event of a deteriorating patient.

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. We observed a range of information available for patients to empower them to live healthier lives, which would enhance their recovery post-surgery.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. This was completed during the pre-operative assessment period. Where additional measures were advised, staff signposted them to additional services and provided patient information leaflets to support them.

Surgery

Most recently, staff had been providing surgical patients with additional advice on how to lead a healthier life in respect of COVID-19 prior to being admitted for their surgery. All elective patients were provided with an advice sheet on how to maximise their recovery by isolating for 14 days prior to surgery as well as ensuring other measures were adhered to including additional hygiene measures. Staff told us this was introduced to reduce the risk of post-operative complications as a result of COVID-19.

Staff told us they had started to provide patients with 'prehab'. This is advice on how to maximise their time prior to the planned surgery and prepare themselves for recovery afterwards. This involved providing activities for patients to practice which would help them after the procedure but also specific lifestyle advice which will improve their recovery.

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. However, not all staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. Where required, staff used agreed personalised measures that limit patients' liberty.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available.

We observed good examples of consent forms which had been completed with patients undergoing surgery, as well as staff gaining verbal consent prior to performing any procedures or initiating any therapy.

Staff clearly recorded consent in the patients' records. We observed good documentation in patient records around consent. This included obtaining formal consent and where consent for therapy was gained prior to each session.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Where staff were making decisions in the best interests of their patients, we observed good documentation around discussions with the patients next of kin. We also observed care passports and 'this is me' documentation in place to inform staff on what the patient's wishes may include.

We were not assured all staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff from some areas were knowledgeable and confident in how and when to assess patients for capacity. However, staff from one ward told us most patients underwent a capacity assessment. This was not in line with first statutory principle of capacity where it is assumed a patient has capacity unless indicated otherwise.

Information provided after the inspection showed on average 79% of staff had completed mental capacity training. The training consisted of four modules which covered assessing capacity, best interests, depriving someone of their liberties and mental capacity in young people.

We reviewed six records where staff had told us they had completed mental capacity assessments or where they believed the patient lacked capacity. We found three (50%) had been completed accurately and in line with legislation and trust policy. However, we found two patients were missing a mental capacity assessment despite it being documented that staff believed the patient lacked capacity. And one patient had capacity assessment completed but was not decision specific. These were raised with staff at the time of inspection so measures could be put in place.

We were not assured all managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. We requested further information around the services own monitoring of capacity

assessments and any actions taken as a result of findings. We were provided with a trust audit of MCA assessments which did not specifically identify the services performance. However, the result of the trust audit showed there was an improving knowledge of mental capacity and what actions should be taken when a patient is deemed to lack capacity to make decisions.

Staff told us they received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Following our inspection, we requested further information around training for these specific topics. Information showed an average compliance rate across the surgery division of 79%, which was better than the trust-wide compliance rate of 77%.

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 they had received training on the relevant legislation and were aware of their roles within this. Although medical staff occasionally encountered children and young people through emergency work, this was not part of their routine, elective work, however they were still knowledgeable about the legislation regarding children. This included the requirements around Gillick competence.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. When applicable, staff implemented Deprivation of Liberty Safeguards in line with approved documentation. All areas visited were knowledgeable about their patients and those who required additional measures to safeguard them. Where a Deprivation of Liberty Safeguards had been applied for, managers were aware of this and were able to talk confidently about the reasons behind them. They had also supported staff to ensure measures taken to safeguard patients were correctly completed and measures taken to safeguard patients were appropriate. Staff however did tell us patients would usually be discharged prior to any formal assessment being completed by the local authority.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. All staff without exception were able to discuss confidently where to access policies and guidance around capacity and Deprivation of Liberty Safeguards. If any advice was required, all staff told us they would approach either their managers or the safeguarding team.

Is the service caring?

Good 

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed care being provided to patients in a dignified manner. When receiving personal care, staff ensured curtains were closed to protect their privacy and dignity. Patients commented on how they had been cared for in a dignified way. One relative who was supporting a patient had commented on how caring staff had been towards both them and the patient and ensured they took the time to meet the needs in a respectful manner.

Surgery

Patients said staff treated them well and with kindness. All patients told us staff treated them very well, with one patient telling us they were 'lavished with attention by friendly staff'. This made an already difficult experience more tolerable.

Staff followed policy to keep patient care and treatment confidential. However, due to the current pandemic and requirements for wearing masks, staff had found it a challenge to maintain confidential conversations in a bay area due to being required to project their voices at times. Where possible, staff tried to lower their voices when discussing confidential information, but this was a challenge. When staff were having sensitive discussions with a patient's relative, these were usually completed in an area where this could remain 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 told us and we observed them treating all patients with respect and in a non-judgemental approach. Staff were aware of an increase in mental health concerns and discussed examples with us of who they had cared for these patients and respected their individual needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff were able to discuss examples of care when they had respected the specific needs of a patient. Cultural and religious needs were well understood, and staff ensured any specific cultural needs would be considered whilst admitted. Staff also told us the trust had good access to various religious leaders to support patients of all faiths.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff told us providing emotion support to patients had been an important task for them during the COVID-19 pandemic, especially due to the restrictions in place for visitors. Patients had required more support from the staff due to this, to compensate for the inability for their relatives and those close to them to visit and provide some of the support required. All staff including specialist staff met the emotional needs of the patients and in doing so had received some positive feedback from patients and families in how they had approach this. Some staff had even been nominated for trust awards due to how they had supported their patients and relatives. Staff continue to look for ways in how they can meet the individual and emotional needs of patients. With restrictions still in place for visiting, staff have enabled some patients to meet relatives in corridors or outside areas and have always allowed compassionate visits to occur for those who were nearing the end of their life or who had received bad news.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. When distressing conversations were due to be held, staff ensured patients privacy and dignity was maintained, and would seek additional specialist staff to support the patient if appropriate.

Staff demonstrated empathy when having difficult conversations. Patients told us about their experiences of difficult conversations they had with staff whilst admitted. They told us all staff had approached the subject sensitively and compassionately.

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.

Surgery

Staff made sure patients and those close to them understood their care and treatment. Patients told us staff gave them time to ask questions to ensure they understood what they were told.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Patients told us they believed staff tailored conversations to their needs. We observed diagrams within notes which had been drawn to explain procedures to patients, which had been a useful way to supplement the discussion. Where patients had other requirements around communication, staff had taken this into consideration.

Staff supported patients to make advanced and informed decisions about their care. Patients were given all essential information to enable them to make informed decisions and where necessary give informed consent. One patient gave an example of where staff had enabled them to make an informed decision about their post-operative recovery plans. This had been a well detailed conversation which staff approached in a caring and supportive way.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff provided patients with a friends and family test form to enable them to provide feedback on their care.

Patients gave positive feedback about the service. The main source of feedback was through the friends and family test (FFT). Information received after the inspection showed 94% of patients who responded from 1 April 2020 until the time of our inspection rated their experience of the service as very good or good. In addition to the FFT which was completed, we observed some cards thanking staff for the care they provided. We also observed a feature within the new surgical newsletter of a member of staff who had been nominated for a trust award by the relative of a patient they had cared for.

Some surgical wards also collated their own feedback from patients about a range of issues from the cleanliness of the environment to the confidence they had in staff caring for them. All aspects of the survey had a target score to achieve, however only one aspect of the survey (asked about research) met the target. The overall response to the question about nurses talking scored the lowest against the individual target (achieved 82.5% against a 92% target). It was noted however that the response rate to the local survey was significantly lower in some areas (11.7% overall response rate) although F21 recorded a 32% response rate. No details were provided on how the individual areas used this information to improve their services.

Is the service responsive?

Good 

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

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the needs of the local population. Managers told us this had been a challenging time due to the pandemic, however they continued to work with commissioners, other NHS trusts and independent providers to ensure surgery services were available and accessible for patients.

Surgery

Changes to the service had been made to try and maximise the flow for surgical patients and to work on reducing the patients waiting for operations. The service had opened a post anaesthesia care unit (PACU) to enable them to continue performing high risk surgeries on patients who would usually require a short admission in a high dependency area. The PACU meant these patients would remain under the care of recovery and ward staff therefore reducing the demand on a service which was already under pressure due to COVID-19 patients. Due to the positive impact that PACU had on the flow and capacity for surgery and reducing the demand on the critical care services, managers were writing a paper to make a case for a permanent enhanced recovery area.

On E14, eight level one beds had also been established to recover patients who required closer monitoring due to the surgeries they had undergone or previous comorbidities they may have. These patients would usually have a short admission in a high dependency area, but the introduction of these beds meant patients would return to the ward and reduce the demand on the high dependency unit.

The service had continued to offer patients the option of having their pre-operative assessments completed virtually due to the positive feedback. This enabled staff to ensure those patients who required a physical appointment for their assessment could be seen.

Wards had been configured differently to maximise admissions and ensure patient safety. E14 had been declared as a 'purple ward' and only admitted elective patients who had undergone the required isolation period and testing prior to admission. Other wards were a mixture of elective and emergency pathways and divided the ward into areas to accommodate this.

Surgical assessment units had been reconfigured to enable a more effective and swift flow through the hospital.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. There had been no reported mixed sex breaches between May 2020 to May 2021.

Facilities and premises were appropriate for the services being delivered. Staff told us there were challenges with the premises due to the age of the building, however they had worked with what they had and were able to deliver effective services.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems. However, additional support for patients with learning disabilities and patients living with dementia were not accessible 24 hours a day. Staff told us specialist nurses were able to provide support and advice to them during normal working hours, however they were not 24 hours a day, seven days a week (on-call) service. Staff were however complimentary about the support and advice they provided them.

The service had systems to help care for patients in need of additional support or specialist intervention. Any patient who was identified as requiring additional support would have a referral done to the appropriate service. This was also carried forward to the community if required.

Managers monitored and took action to minimise missed appointments. Managers ensured that patients who did not attend appointments were contacted. Staff told us since offering both virtual and physical pre-assessment appointments, this had reduced the number of appointments where patients did not attend or cancelled at short notice.

Surgery

Managers told us the changes to the surgical assessment unit had reduced the demand and pressures on the emergency department (ED). Similarly, changes to how spinal services and neurosurgical services were managed had meant a more efficient flow through the service with an increase in the number of patients discharged home the same day. Similarly, the introduction of the PACU and level one beds on E14 had reduced the demand on the critical care services.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff ensured specialist staff were involved in their care when required and welcomed relatives and carers in to support the patients if their needs required this. In addition to this, we observed similar processes were in place for those with brain injuries to ensure their needs were also met. Staff and relatives discussed examples of when steps had been taken to ensure measures were in place to meet the needs of patients. We also observed clear documentation for a patient around their specific requirements to ensure a positive patient experience.

Wards had been modified to meet the needs of patients living with dementia. The main modifications made were to signage and the décor of the wards to make them more dementia friendly.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. We also observed these being used in additional areas to support patients who had specific needs. An example of this was patients on D10 who had brain injuries. This enabled staff caring for them to meet their individual needs.

Staff understood the policy on meeting the information and communication needs of patients with a disability or sensory loss, however recent challenges with the pandemic had impacted how staff met patient needs. Staff told us they were aware of the challenges when communicating with patients who had a hearing impairment due to the requirements for wearing masks all the time. Some staff were aware they were able to request signers for patients who used sign language. Other staff told us they would write down information for patients who were hard of hearing. Minimal numbers of staff were aware of clear masks which were available to help patients lip read and no staff had enquired whether the trust were able to purchase these to enable them to meet their patient needs. The spring newsletter produced by the service featured an article on how staff in the audiology department were striving to improve communication with patients with a hearing impairment. None of the staff we spoke with were aware of this article.

Staff on one ward also told us they were aware of staff in the service who were able to competently use Makaton to communicate with some patients. They had previously liaised with them when they had a patient who they required support with.

The service had information leaflets available in languages spoken by the patients and local community. Most of the information leaflets that we observed which were readily available were in English. However, staff assured us they had access to information leaflets in a range of languages to meet the needs of patients.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff told us they had no concerns over the access to interpreters for their patients. For elective patients, they were able

to pre-plan when they would require interpreters to attend the ward areas. Staff gave an example of a patient who went to theatre with their interpreter present to confirm consent prior to being anaesthetised. In emergency situations, staff told us they would use a telephone interpretation service or would use a translation application on their electronic devices.

Patients were given a choice of food and drink to meet their cultural and religious preferences. The service had also completed an educational piece in their spring newsletter around the importance of Ramadan to help staff care for Muslim patients who were observing this holy period. The article provided staff specific information around fasting and how this may impact patient's health and well-being.

Some staff had access to communication aids to help patients become partners in their care and treatment. When asked about meeting the individual needs of patients, some areas had access to more resources than others. On D10, staff had boxes to help them meet the needs of the patients on their wards which included communication aids. However, this was not the same in all areas.

Access and flow

The pandemic had impacted how people accessed the service. Waiting times from referral to treatment had grown, however arrangements to admit, treat and discharge patients remained in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed. However, the pandemic had impacted some patients receiving treatment within agreed timeframes and national targets. The pandemic had impacted the number of patients who were waiting for treatment. Trust wide at the end of March 2021, there were 50,633 patients on the waiting list. This was an increase of 20% from the previous year. A comparison of elective admissions for treatment between September 2020 to February 2021, to the same period the year before demonstrated a loss of capacity of 31% due to the pandemic. Although this was having a significant impact on the service, this was less than the national average of a 35% loss in capacity. Information received from the service after the inspection showed between June 2020 and May 2021 there were 9,863 patients admitted for elective surgery and an additional 50,947 patients treated as an elective day case.

During the pandemic, the service were supported by three independent providers to ensure patients who required urgent surgeries were operated on in an optimal time. Information provided by the service showed there had been 1,873 operations performed across the three hospitals between August 2020 and June 2021.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. Staff told us patients who attended the hospital as an emergency had very little impact on their ability to receive the required treatment. Information received after the inspection showed between June 2020 and May 2021 there were 20,918 patients who received surgical intervention as an emergency case.

Managers and staff worked to make sure patients did not stay longer than they needed to. Between February 2020 to January 2021, the overall average length of stay for patients under the elective pathway at this location was 4.4 days. This was slightly above the England average of 4 days. Between the same time period, the overall average length of stay for patients under the emergency pathway at this location was 4.9 days. This was higher than the England average of 4.3 days.

Surgery

Managers made sure they had arrangements for surgical staff to review any surgical patients on non-surgical wards. If surgical patients were admitted to a non-surgical area, there were processes in place to ensure they received appropriate reviews.

Managers worked to minimise the number of surgical patients on non-surgical wards. At the time of our inspection, there were no surgical outliers (surgical patients on non-surgical wards).

Managers worked to keep the number of cancelled operations to a minimum. Information received after the inspection showed between June 2020 and May 2021 there were 261 operations cancelled on the day of the planned procedure at this location. The main reasons for operations being cancelled were staffing availability, equipment being unavailable and the lack of intensive care and high dependency beds for patients post operatively. The largest number of operations cancelled on the day of planned procedure were recorded during December 2020. This related to a hot water estates failure limiting the ability to sterilise equipment and was a one off unforeseen issue that impacted December's figures.

The service had a dedicated flow matron and coordinator who maintained an oversight of the pressures the service was under to try and ensure patients were not impacted. Regular meetings were held throughout the day and a report of the overall divisional status of flow and capacity produced for the senior leadership team. We observed a flow meeting during our inspection and found they were well organised and well ran. At the meeting we attended, staff had identified capacity was high (97%) which was a critical trigger. We observed how all attendees worked through the concerns and identified a plan of action.

Staff told us when patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible. Prior to the pandemic, of the procedures which were cancelled on the day, the service rescheduled 90-95% of them within 28 days of the cancellation.

Managers monitored that patient moves between wards/services were kept to a minimum. The service moved patients only when there was a clear medical reason or in their best interest. Due to the concerns and challenges around the pandemic, this had reduced the bed moves further. Staff told us they would only move patients around when there was a legitimate reason to do so. Patients who were admitted under the purple pathway would only be able to move around the purple area and would not be moved into an alternative pathway unless their status indicated a requirement to do so. For patients who had cognitive impairments, staff always tried to keep moves to a minimum and would only move during night-time hours if it was for safety reasons.

Managers and staff worked to make sure that they started discharge planning as early as possible. Information around patients' social circumstances which may impact discharge was gathered during their pre-assessment appointment. A patient discussed their experience around this which as a result of the information gathered at their assessment had identified they required an inpatient stay at a rehabilitation ward.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Staff told us there was a multidisciplinary team (MDT) approach to complex discharges, including the involvement of discharge coordinators.

The formal monitoring of delayed discharges was suspended at the beginning of the COVID-19 pandemic as directed by the national guidance. Staff told us the service was keen to have oversight of this, and so had participated in the

monitoring of the 'reason to reside' process over the last 6 months. There were 6,617 episodes of delayed discharge (counted from 24 hours on wards) between 23 November 2020 to 24 June 2021. The main reasons for this had been down to waiting for assessments and rehabilitation or reablement placements. This period covered a time when the surgical wards were also caring for COVID-19 positive patients as well.

Staff supported patients when they were referred or transferred between services. Staff ensured all patients transferred from the wards were done so in a safe manner. Handover details were provided both verbally and in writing and staff accompanied their patient during transfer.

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. Patients told us they felt comfortable raising any issues with the staff caring for them at the time. However, no patients or relatives we spoke to at the time of the inspection had concerns which they needed to raise.

Staff understood the policy on complaints and knew how to handle them. Staff tried to resolve any complaints or concerns locally; however, they were aware of the escalation policy if this was required.

Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers we spoke with were knowledgeable about the complaints they had received and the investigation process they used. All managers we spoke with told us they had received low numbers of complaints over the last 12 months. Information received after the inspection showed the service had the 144 complaints between June 2020 and May 2021. Of these, 38 were still open and being investigated and four had been referred to the Parliamentary Health Service Ombudsmen for an independent review of the concerns raised and how these concerns had been initially addressed. The main concerns raised through the formal complaints procedure were in relation communication and basic care.

Managers shared feedback from complaints with staff and learning was used to improve the service. Complaints were discussed at divisional governance meetings and then cascaded down to all ward and department areas where learning could be implemented.

Staff could give examples of how they used patient feedback to improve daily practice. In some areas we visited, we observed information on how they had used patient feedback to improve their services.

Is the service well-led?

Good ↓

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

Surgery

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 surgery services crossed over five divisions at the trust (surgery, medicine, clinical support, ambulatory care and cancer and associated specialities). Each division had a similar triumvirate leadership in place of a general manager, divisional director and a divisional lead nurse. Surgery and clinical support were the largest divisions which covered the surgery service. Within them, they had divided down into pathways which had their own triumvirate leadership in place. This provided an additional level of oversight and streamlined the governance process. Most staff told us they regularly saw their pathway leads and would feel comfortable approaching them for support.

Local leadership was provided by matrons and ward managers. All staff we spoke with spoke positively about their local managers and matrons, and without exception told us they were supportive, approachable and extremely visible.

Junior doctors told us they felt well supported by their registrars and consultants and spoke of how approachable they were. Some junior doctors told us they had such positive experiences at the location that they were keen to stay on past their junior doctor rotations. They believed the leadership had managed the redeployments well over the pandemic which meant there was minimal disruption to their learning opportunities.

Most staff were aware of the executive team with staff commenting on the impact that had already been made by the new chief nurse. At the time of our inspection, the chief nurse had been in place for less than a month, but staff were already aware of who she was and were positive about the direction she wanted to go. There was also a lot of praise about the availability and visibility of the medical director. However, there were some staff who told us other members of the executive team were not very visible, and less so during the pandemic, however staff acknowledged it was a large trust and difficult to be visible.

Vision and Strategy

The service followed the trust vision and values. However, the service had completed specific priorities for what it wanted to achieve. The priorities were mainly focused on recovery following the pandemic, as well as sustainability of services. Leaders and staff understood and knew how to apply the priorities and monitor their progress.

All staff had a good awareness of the vision and values of the trust, and ultimately how they wanted to become outstanding in health outcomes and patient and staff experience. ‘Team NUH’ was well embedded and staff talked about how their work reflected:

- Trust - Nurturing
- Empower - United
- Ambitious - Honest
- Mindful

Staff had previously been given the opportunity to be involved in the developing the ‘Team NUH’ trust vision, values and behaviours.

Surgery

The trust had implemented their 10-year strategy in 2018, with six key promises on how they intended to achieve their objective of becoming outstanding in health outcomes and patient and staff experience. Considering the recent pandemic, the service devised their key priorities which were included in their annual plan for 2021/22, which would underpin the overall trust strategy (in particular promise four- performance). The service's priorities were largely focused around how they intended to recover from the turbulence of the pandemic and restore their service to enable them to manage the increasing demand for the service. Staff were aware of the overarching priority to restore the service and catch up on the increasing backlog of patients.

Culture

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

All staff we spoke with without exception told us they felt valued, supported and respected by their leaders and by their peers. Staff were aware of the challenges experienced within maternity services and how that had impacted the culture but told us the culture in their service could not be more different.

Managers were aware of the impact the pandemic had on staff and that staff in some areas were close to burn out. Some managers told us they had referred some of their staff for further support for their health and well-being. Staff were aware of the well-being support that had been implemented by the trust and knew their own local managers were supportive of them accessing these. Staff felt their well-being mattered to their local managers. Despite the challenges and ongoing requirements for support within the service, morale was reasonably high.

All staff we spoke with told us the service was patient centred and they were committed to ensuring patients had a safe and positive experience whilst admitted.

Staff told us there was an 'open door' approach to all managers and leaders in the unit. If there were any concerns, staff felt they were able to raise them without fear of reprisal. Staff were also aware of the Freedom to Speak Up Guardian and knew who their guardian was at the trust. Junior doctors were also aware of their guardian for safe working and how to escalate concerns if they had any, however all commented on how happy and supported they felt.

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

Governance

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

There was an effective corporate and local governance framework which had the ability to oversee service delivery and quality of care. The introduction of pathways and local leadership of the pathways meant the governance responsibility was held by clinical staff with overall oversight by the divisional leads. Meetings were held on a regular basis within the separate pathways to discuss key issues such as incidents and complaints, risks, best practice guidance, audits and

lessons learnt. Any areas of concern were escalated to the overall divisional senior leadership team, or on occasions had been raised directly at trust level meetings. We reviewed the minutes of governance meetings and saw a standardised approach to the meetings which covered all pertinent governance points. We saw clear actions identified within the minutes and areas which required escalation. Due to the suspension of more local meetings (ward meetings) there was minimal evidence to demonstrate that key messages were being cascaded down to the staff. We did observe some minutes and newsletters which some wards had produced which did evidence some flow of important information and learning from meetings.

Ward meetings had been scaled back in most areas, with most staff telling us these had not yet been rescheduled. There were some areas which had started to schedule team meetings however there were challenges around this due to the ongoing restrictions in place. One manager told us they were considering using software to enable staff to dial into a meeting, reducing the number of staff all in one area. In other areas, managers had implemented a newsletter to update staff on key messages which had been received well. In addition to this, most areas had private chat groups where key messages and updates could be discussed.

Divisional senior leadership teams maintained oversight of the number of incidents being reported within the service and distributed immediate learning as required. However, information received after the inspection identified there were 808 incidents open and waiting for investigation. Information received after the inspection indicated this was a wider problem than just the service and plans were being implemented to change the management of incidents and clear the backlog which had built up.

There was a sepsis lead within the service who attended the governance meetings which were regularly held. We saw information which had been presented to the senior leadership team around unplanned admissions from the service to critical care as a result of sepsis. However, managers told us they had not received updates around performance on the 'sepsis six' for a long time which was an area they found useful and would escalate this to ensure this was re-started.

Management of risk, issues and performance

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

The surgery division had a risk register in place which contained 195 risks, of which 22 risks were graded high or significant. The top three risks which were on the risk register were the same top three risks discussed by the senior leadership team. There was evidence within minutes of governance meetings where risks on the register were reviewed on a regular basis, however the risk register had 23 risks on there which had not been reviewed in the last 12 months, with two risks not appearing to have been reviewed since 2013.

The senior leadership team told us they had been holding risk clinics for staff to drop into where they were able to discuss issues with risks and move them along. Information received after the inspection identified risks were reducing month after month which was partly as a result of these risk clinics. There were however new risks being added to the register some of which were as a result of the pandemic (both directly and indirectly). The risk register showed there were 21 new risks which were under development at the time of our inspection.

Within the surgery division, staffing was one of the largest risks previously, however they had worked hard on this risk to ensure rolling recruitment programmes were in place to keep vacancies low. This was now recorded as a moderate risk on the risk register as opposed to a high risk.

Locally, managers monitored risks, issues and performance through their dashboards. The nursing and midwifery dashboard held information against 23 metrics. Information was gathered on a monthly basis and the results available for all staff to review on the intranet. Each metric had a 90% compliance target. Where areas failed to meet this target, this was reviewed at the governance meetings and managers meetings.

The service had also introduced 'Perfect Ward' which is a quality improvement programme. Staff told us this had been suspended during the pandemic and had only just restarted again so were unable to identify any changes as a result of this system.

Managers were all able to identify their own largest risks and escalated these to the pathway leads if they were not mitigated effectively. The largest risk which was identified in all areas was in relation to the rise of pressure related damage to patients. All staff told us there was a focus on improving the management of patients at risk of developing or who had already developed pressure ulcers.

Managers and staff from the harm free care team regularly met to discuss risks and areas of concern within the service. They reviewed significant incidents in relation to harms including but not limited to, falls and pressure ulcers and looked at implementing learning and improvement strategies.

Information Management

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

The service collected reliable data and analysed it. Staff told us they had administrative support to help collect reliable data for national audits to ensure accurate collection and submission of the data. The service also ensured there were systems in place to submit required information to external organisations, such as surgical site infection data and numbers of alert organism infections.

Staff had access to the most current information on performance via the dashboard data on the intranet. This enabled all staff to identify where improvements were required but to also share best practice.

Staff in most areas had access to information technology (IT) systems to enable them to provide care and treatment to patients. However, some staff had identified significant challenges with IT, especially around the system for sharing radiology reports. In addition to this, some areas did not use the systems which were in place across most of the trust. Staff told us this could also be challenging at times to ensure accurate information is handed over during a patients span of care. Although staff commented on the challenges this presented, there was no evidence of patient harm as a result of this.

Staff were aware of how to use and store information securely and confidentially, however we found patient records in trolleys which were not locked.

Engagement

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

Staff participated in the trust's staff survey. Results for the division showed 765 staff (33% of the division) participated in the survey. This was below the national average participation rate of 45%. Of the 10 reported themes, the service

performed better or the same in eight themes as the overall trust performance. The two areas where the service performed worse than the overall trust performance was around a safe environment from violence and team working. The leadership team for the service produced an action plan of how they intended to address the areas where they identified some concerns.

The service had worked closely with local independent health providers during the pandemic to enable them to continue to provide care and treatment to those patients who required urgent treatment (for example patients on a cancer pathway).

The service had a people's committee which met monthly. Staff were invited to join the committee as representatives and a one-page summary of key issues was produced following the meetings for all staff to review. Additionally, the service had started to develop a newsletter for staff which also included staff stories on various topics.

Staff had set up closed social media groups to enable them to engage with each other privately. Staff told us these were key during the pandemic as they were able to keep in touch with staff and check on each other, as well as communicate important issues.

Staff told us they use family liaison officers when completing serious incident investigations, this ensures the patient and their family have a constant presence communicating with them during the process.

The trust had a range of ways in which they sought to engage with patients and members of the public to help plan, develop and manage services. Senior leaders from within the service are involved with these committees and meetings to help develop the service further. Staff told us there were usually events publicised on the internet page where members of the public can attend and engage with the trust, however due to the pandemic, these have been impacted and staff were not aware when any future events would run.

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.

Staff were constantly looking for opportunities to improve the services provided. Quality improvement projects had been a key to driving improvement within the service. All staff were encouraged to be involved in the quality improvement projects. Information received after the inspection showed there had been several quality improvement projects completed over the last 12 months. The most widely known about project within the service was around the improvement project for pressure ulcers.

Staff also participated in research projects to try and improve care and treatment for patients passing through the service, as well as improving the overall patient experience of being admitted to hospital. One piece of research which was in the early stages of being scoped was around the impact of the pandemic on surgical patients who were delayed or cancelled from undergoing their procedure. This was an area of interest for a lot of staff within the surgical services due to the awareness of a growing waiting list and the challenges still in place at the trust.

Surgery

During the pandemic, the service established a surgical prioritisation group which reviewed patients who needed to undergo procedures against capacity. Staff told us these meetings were useful to ensure those who needed the service first, received the treatment. These meetings were patient focused and enabled the service to continue to provide a service at a time when most other trusts were having to completely suspend their activity. As a result of the work they completed, members of the group produced a paper to share their learning with others.

Senior leaders from the service told us they were intending to develop their technological input into surgery using robots. Once surgeons were trained to use the technology, this would improve outcomes for patients by reducing complications and enabling patients to recover faster. This would also reduce the impact on the surgeon themselves (less incidence of repetitive strain injuries for surgeons).

Urgent and emergency services

Requires Improvement

Is the service safe?

Requires Improvement

Mandatory training

Staff had not kept up to date with their mandatory training because management of the Covid-19 pandemic had taken priority.

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

Managers monitored mandatory training and alerted staff when they needed to update their training.

Staff had access to a comprehensive range of mandatory training including equality and diversity, health safety and welfare, infection prevention and control, fie safety, conflict resolution, safeguarding, manual handling, resuscitation and dementia. Staff could access a designated research and education facility which was co-located within the emergency department.

In light of continued staffing pressures placed upon the trust during the covid-19 pandemic, staff reported, training and accessing mandatory training had been paused in order that staff could be deployed to provide frontline care. The department was however working to improve compliance with mandatory training and reported a recovery plan had been established.

At the time of the inspection, the department had met or exceeded the trust compliance level of 90% for equality, diversity and human rights; infection prevention and control level 1 (non-clinical), manual handling (level 1) and safeguarding level one.

The department was rag rated amber for eight additional modules (health, safety and welfare; infection prevention and control level 2; information governance; preventing radicalisation; safeguarding level two and three; manual handling assessments; fire safety; and dementia). The department was rated red for three modules including NHS conflict resolution; resuscitation level one; and resuscitation level two.

A range of training days had been scheduled in order that staff could update themselves in the relevant mandatory training and evidence of this was seen during the inspection.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff attempted to use equipment and control measures to protect patients, themselves and others from infection however departmental over-crowding made this difficult to achieve. They kept equipment and the premises visibly clean.

Staff followed infection control principles including the use of personal protective equipment (PPE). However, the department was often over-crowded resulting in patients not being socially distanced from one-another.

Urgent and emergency services

In response to the covid-19 pandemic, the department had created a four-cubicle isolation area to help manage patients who presented with covid-19 symptoms. The area was staffed by designated staff who were, for the duration of their shift, isolated from other staff and patients in the emergency department. Arrangements had been made for isolation area staff to have access to designated rest and welfare facilities to help reduce the risk of transmission of covid-19 to staff and patients. Point-of-care testing facilities were available and co-located within the department which enabled staff to undertake rapid testing of all patients and to identify and isolate patients who tested positive for covid-19 or flu. Staff used their clinical judgement in cases where a test result reported either a negative or inconclusive result, especially in cases where it was highly suspected a patient may in fact have been a carrier of covid-19. We did observe one occasion when a staff member, who was donned in level three personal protective equipment and who was working in the isolation area, exit the isolation area and start speaking with members of staff from other areas of the department. A member of staff challenged the individual and reminded them of the importance of remaining in their designated area.

Staff acknowledged that whilst there had been a reduction in the number of patients attending the emergency department (ED) with covid-19 like symptoms, the designated four cubicles were not always enough to meet demand. We observed one patient who self-presented to the main reception area of the ED; they reported having a new onset, active cough which was one of the main symptoms for Covid-19. Because the isolation area was at full capacity, the patient remained in the waiting room for approximately twenty minutes whilst capacity was created to be able to isolate the patient. The waiting room was busy and at capacity and whilst the patient was compliant with wearing a fluid repellent surgical mask, they remained in a populated general area for an extended period of time.

Staff spoke about local escalation protocols and how these were enacted when demand outstripped capacity, however environmental challenges meant it often took some time to enact the local covid-19 surge protocol, thus creating delays with patients being isolated quickly.

In recent months, staff reported a significant increase in the number of patients attending the emergency department. Historically, the department treated approximately 550 patients per day however on Monday 12 July 2021, the department had seen and treated 695 patients; the highest number of attendances ever reported. The increasingly high number of attendances and delays in patients being seen, treated and discharged or admitted meant the department was, at times over-crowded with patients being managed in non-clinical areas including corridors and within the general areas of majors. We observed patients being cared for in close proximity to one another and whilst staff made efforts to ensure patients wore appropriate fluid repellent surgical masks to aid the reduction in the spread of respiratory borne infections, patients could not be socially distanced from one another. Staff acknowledged the situation was not appropriate and there was an inherent risk patients and staff could be exposed to patients who may have been asymptomatic carriers of Covid-19.

Staff adopted to wear level three personal protective equipment when working in the majors area and when the department was in surge capacity to help mitigate risks to them, however this was not feasible for patients. We observed frail elderly patients being cared for next to workstations within the majors area during the inspection. Whilst these patients were provided with fluid repellent surgical masks, they were often not wearing them, or masks were only covering an individual's mouth and not their nose, therefore providing little protection to others.

The trust acknowledged our concerns about the risk of harm associated with nosocomial infections and following the inspection, reported a range of actions they had agreed to take. These included working with the provider of the urgent treatment unit (UTU) to ensure there was sufficient cover in the UTU 24 hours a day from 2 August 2021. This would

enable more patients to be seen and treated through the primary urgent treatment pathway rather than being seen and treated in the majors department. Additional primary care capacity had also been provided at an off-site urgent care centre. ED staff could signpost relevant patients to this offsite service to help decompress the demand placed on the ED pathway.

The trust further reported: the establishment of a service with a third party provider, to go live from 2 August that would initially provide interim packages of care for patients who required a restart of their existing package of care on discharge to ensure they were able to leave hospital on the day they were medically safe to do so. This service was aimed at supporting an additional six to eight discharges per day initially to help decompress the majors area and to aid more timely admissions direct from the ED.

Additionally, the trust reported the Local Authority would be providing an additional 150 care hours per week which was to be phased in from 2 August. These additional care hours would be used to address a designated range of patients waiting for discharge to specific care pathways for the City Local Authority which was reported to be between seven to 12 patients over the recent weeks.

Arrangements were also made with local commissioners and community health providers for the trust to utilise empty pathway two bed capacity to provide interim solutions for patients requiring packages of care through which the trust anticipated releasing six additional beds.

These combined actions were designed to release up to 26 beds to support downstream flow which would in turn reduce overcrowding in ED. The trust also reported they would review their risk assessment related to nosocomial spread across both inpatient and Emergency Department Majors areas with respect to capacity and balance of risk in light of COVID, infection prevention and control recommendations and increased emergency demand. This was scheduled to be completed by 6 August.

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

Staff were observed cleaning equipment between patient use. Staff decontaminated their hands frequently and wore appropriate levels of personal protective equipment. Clinical waste was stored securely.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe.

Patients nursed in cubicles could reach call bells and staff responded quickly when called. However, over-crowding within the department meant patients were not always in direct line of sight of staff.

There was a high level of anxiety among staff working in the emergency department (ED) about the overall lack of capacity and space to meet current demand. A range of escalation protocols had been established to support what had been reported as a longstanding challenge. The majors area of the ED had 30 cubicles with an additional six lower acuity cubicles located just outside the main area. Staff reported, and we observed during the inspection, that at times of high demand, patients were nursed outside cubicles, next to workstations and desks.

There existed a standard operating procedure (SOP) which detailed the types of patients who could be nursed within these non-clinically designated areas. We reviewed patients who were within the non-clinical areas; in the main, these were frail elderly patients, some of whom were mildly confused or disorientated. Staff considered one patient who had been moved to the communal area and who was in a confused state may attempt to climb from their trolley and

potentially harm themselves by falling. Staff therefore felt it was appropriate to try and mitigate such risks by allocating a healthcare assistant to remain with the patient. Although we did not see any evidence on the day of the inspection, staff reported it was not uncommon for patients to be moved to the central communal area who were not always appropriate. These decisions were based on the needs of patients who were waiting to be clinically assessed and treated alongside the needs of patients already in the department. It was clear from our interviews with senior nursing and medical staff they were not complacent when reaching such decisions and were able to describe the mitigations and actions they took.

Staff reported they were concerned by the lack of line of sight of patients when they were over capacity (or at critical or maximum capacity when referencing local trust SOPs). Although the staffing establishment was reviewed frequently, it was reported it was often challenging to resource the department when it was over capacity. This resulted in patients being nursed in areas where a member of staff was not always present. Hourly rounding was completed by nursing staff to ensure patients remained comfortable however staff were concerned with issues such as falls and a lack of privacy and dignity when patients were nursed in communal areas. We noted falls were a significant area for concern among staff, in part because of a rise in falls in the department. Thirteen falls had been reported in June 2021 of which one resulted in low harm to the patient.

Themes around why patients fell had been considered at local governance meetings with reasons given as “toileting, agitation, confused patients, supervision of patients”. Staff could describe a new falls risk assessment which was being developed alongside the establishment of a local falls team tasked with reducing falls across the emergency department.

Staff carried out daily safety checks of specialist equipment.

We sampled a range of emergency equipment. Checks were completed frequently by staff to ensure equipment was available and fit for purpose.

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

The department had two rooms designated for caring for patients who presented in a mental-health crisis. Local risk assessments existed which demonstrated staff had considered the needs of patients with suicidal ideation. Both rooms had been placed and designed to reduce the risk of patients being able to use fixtures or fixings as ligature points.

Assessing and responding to patient risk

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. However, processes for the assessment of patients who self-presented to the ED were not fit for purpose.

Patients conveyed by ambulance were initially assessed by nursing and allied health professionals at the “First contact” point. Standard operating procedures were in place which helped support staff with the processes they should follow when working in the first contact area. Nursing staff received an initial clinical handover from the ambulance crew, in the presence of the patient. Nursing staff then undertook their own assessment of the patient and were able to commence first line diagnostic interventions including ecg’s, blood test and point of care tests. Nursing staff then assigned patients to the most appropriate clinical pathway and could easily escalate patients for rapid clinical assessment if necessary.

Urgent and emergency services

Patients who self-presented to the emergency department (ED) were required to register with the receptionist who was located behind a window. Patients were asked to provide their personal details alongside their presenting complaint. Co-located at the reception desk was a senior nurse who undertook streaming duties as defined by the Royal College of Emergency Medicine (RCEM) triage position statement.

During the inspection we noted the receptionist registered the patient on the ED system; the patient was then directed to the nurse who was also present at the reception desk. The nurse attempted to take a brief history from the patient and then assigned the patient to the most relevant clinical pathway.

Manchester Triage was the main system in use however, the process was fragmented and there was a risk of delays if the urgent treatment unit was at surge, as was the case on the day of the inspection. At approximately 11:40, six patients stood in the queue waiting to register. The triage (streaming) nurse moved between the receptionists asking patients questions as part of the assessment. The triage nurse assessed each patient as they registered and then entered their assessment on the electronic patient record. The nurse was observed completing the triage documentation for multiple patients thus increasing the risk of error such as the incorrect assessment being recorded against the wrong patient.

At 12:15 the queue to register had increased. One patient was pregnant, and the streaming nurse attempted to refer the patient to the labour suite and was observed to be on the phone for some time. Whilst the nurse was on hold on the phone, we observed them attempting to take a history from another patient who was booking in. The streaming nurse was obviously pre-occupied with making the referral and therefore could not dedicate their full attention to the other patient.

We observed that if the streaming nurse was busy and was not able to listen to the patient during registration, the receptionist handed details of the patient to the nurse. This was observed on two occasions. One patient registered complaining of an insect bite with possible cellulitis (a form of localised skin infection) and chest pain. The streaming nurse did not assess the patient themselves but instead wrote the triage and assigned the patient to the urgent treatment unit pathway. We noted the time at registration was 12:18. The initial triage was recorded at 12:31. Enhanced triage was carried out at 12:55 with an electrocardiogram (ECG) having been completed at 13:49. There was a protracted delay in the patient having a full clinical assessment as was recommended by the Royal College of Emergency Medicine.

Once the streaming nurse had assigned patients to the relevant clinical pathway, patients would then undergo clinical assessments if they had been allocated to the majors pathway. However, a lack of space in the department and high attendance rates meant there were often delays in patients receiving this initial clinical assessment. There was an inherent risk that acutely unwell patients may not be immediately recognised. Local managers acknowledged the need to improve the time to initial assessment and had reviewed workstreams, as well as responding to high demand by flexing the staffing establishment however this had remained as a work in progress.

We were sufficiently concerned by the delays which patients experienced when they self-presented and therefore raised these concerns with the trust executive team on completion of the inspection, and formally in written correspondence shortly after the inspection. The trust acknowledged the concerns and provided assurances by way of a range of actions they had agreed to implement. These included moving the right numbers of qualified staff to work in designated clinical assessment rooms from 26 July 2021. This would enable patients to be seen and assessed more quickly and therefore prioritised where required. A review of metrics provided by the trust following the inspection demonstrated that the changes they had made following our feedback was starting to deliver improvements in the time it took from patients

registering to being clinically assessed. For example, for the week of our inspection, the percentage of patient who received an assessment within 15 minutes was 17.6%. Following our feedback this had improved to 37%. The trust still had significant work to do to ensure this metric improved further however we acknowledged the improvements made over a very short period of time.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

Patients received a comprehensive assessment in line with clinical pathways and protocols. Patients were assessed using a range of national evidence-based tools. This included sections for clinical observations (national early warning score), Glasgow coma scale and details of past medical history, complaint history and a section for treatment plans. These were completed by the nurse and doctors attending the patient and clearly described the assessment process, treatment given and planned, and the outcome of any investigations.

The national early warning score (NEWS2) and the paediatric early warning score (PEWS) were used to identify deteriorating patients in accordance with National Institute of Health and Care Excellence (NICE) Clinical Guidance (CG) 50: 'acutely ill adults in hospital: recognising and responding to deterioration' (2007). We looked at 12 NEWS/PEWS logs and saw that they were completed correctly and regularly. NEWS2 is a point system implemented to standardise the approach to detecting deterioration in patients' clinical condition. On the charts reviewed, clinical observations were repeated in line with the previous score and escalated when scores were elevated.

Information was available to help staff identify patients who may become septic. Sepsis is a serious complication of an infection. We saw the records of five patients in the department who had the sepsis pathway implemented. All charts we reviewed showed diagnostic and initial treatment was completed within one hour of identification of sepsis. This was in line with the NICE guideline (NG51) Sepsis: recognition, diagnosis and early management. However, because of high demand and a lack of capacity across the department, patients often experienced delays before being seen and treated by a doctor or advanced clinical practitioner. These delays meant some treatment protocols were not commenced as quickly as they could have been had the patient not experienced the initial delay.

A local audit was completed by the sepsis team in July 2021 and considered 100 patients who had been commenced on the sepsis pathway during the preceding year. 92% of patients received a medical review within 30 minutes. 82% of patients were commenced on antibiotics within one hour; 45% had a single blood culture completed; 44% had two cultures completed (as is recognised as best practice) and 11% had no cultures. Action plans had been developed to further improve overall compliance with the local sepsis care bundle as well as adaptations being made to the bundle to trial an eSepsis bundle being piloted.

Nurse staffing

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

The service did not always have enough nursing and support staff to keep patients safe.

The department had a budgeted nursing establishment of 205 whole time equivalent (WTE) posts. At the time of the inspection, there were 25.3 WTE vacancies, equating to a vacancy rate of 12% but included funding to accommodate for the demands placed on the service through covid-19 challenges.

The highest percentage of vacancies existed within the band six cohort (10.3 WTE posts) however six of these vacant roles were associated with the temporary covid-19 uplift. The trust used bank and agency staff to back-fill vacant gaps. Temporary staff were orientated and inducted to the clinical area.

Senior staff reported challenges with being able to flex the workforce to meet unprecedented demand. Whilst managers had risk assessed and planned the establishment based on historical activity, the unprecedented demand had resulted in nursing staff having to work dynamically to ensure patients were kept safe. As has already been reported, challenges existed with being able to provide sufficient nurses to clinically assess patients when they first arrived, as well as ensuring there were sufficient nurses to care for all patients in the majors department. To help support the ongoing recruitment of nursing staff within the Emergency Department (ED) a recruitment and retention lead, commenced in post 1 June 2021. A rolling advert continued to be published for band five nurses with the intention of attracting sufficient candidates to enable the local management team to over-recruit to the department. A further 3.5 WTE children's nurses were undergoing pre-employment checks at the time of the inspection. Further adverts had been placed for band six roles and an internal advert had been placed to recruit an additional matron for the children's ED on a six-month basis to help support the expansion of the department.

Between July 2020 and June 2021, the turnover rate for registered nurses was reported as 8.61%. The absence rate for the same period was reported as 3.09%.

Medical staffing

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

The service did not have enough medical staff to keep patients safe.

A total of 29.7 whole time equivalent (WTE) consultant posts were reported by the trust. There were 26.55 WTE in post with three vacant posts being recruited into. This included 5.42 WTE posts which had been created to help manage demand placed on the department because of the covid-19 pandemic. The 5.42 WTE posts identified for covid-19 were non-recurrent and could not be substantively recruited to.

There were four paediatricians who worked to support the children's emergency department alongside a further three paediatric emergency medicine consultants.

The existing consultant establishment enabled the team to provide consultant cover as follows:

Four consultants supported the resuscitation area, majors, urgent treatment unit, and the clinical decision unit between 7.30am and 5pm. One paediatric consultant worked in the children's emergency department 9am – 5pm. Three consultants were present between 3.30pm and 10pm; One consultant present from 9pm – 2am with another consultant present from 10pm – 8am. A review of the medical staffing rota during the inspection revealed night-cover was consistently provided by substantive consultants picking up additional shifts.

The department was funded for 11.80 WTE specialist trainee posts (0.24 WTE vacancies); 19.62 certificate of eligibility for specialist registration posts ((CESR) 6.12 WTE vacancies); and one WTE specialist doctor post. A range of junior trainee doctor posts were also included on the establishment equating to 56.77 WTE posts (2.79 WTE vacancies).

Between July 2020 and June 2021, the turnover rate reported for doctors was 21.78%. The absence rate was reported as 1.49% for the same period.

Urgent and emergency services

There was a general consensus amongst junior, senior and consultant level doctors there was insufficient medical cover to adequately support the department. There was a significant reliance on locum medical staff, which for some was reported to impact on the quality of the service provided. Junior and middle grade shifts, alongside night shifts for consultants were consistently filled with locum doctors despite there being a relatively low vacancy rate. This was reported to be because the baseline establishment was not correct and was not aligned to the Royal College of Emergency Medicine standards for safer staffing.

In 2019 we reported the department did not employ sufficient numbers of medical staff to meet the needs of patients. The Royal College of Emergency Medicine has defined the staffing ratios for departments based on annual activity. The local management team had been working to devise a robust business case to secure the necessary funding to increase the medical establishment. The intention was for the department to be ambitious and to recruit sufficient numbers in order that the department remained sustainable and was able to respond to increasing demand over time. Staff reported frustrations with the lengthy process by which it had taken to progress the business case. There was also concern among the workforce that despite there having been multiple iterations of the business case over a period of 18 months, staff had little confidence that the plan would eventually be approved.

We spoke with eight middle grade doctors. They reported that despite the underlying challenges with medical workforce staffing, one consultant was always assigned to provide training during the day. There was a general consensus that access to supervision was good. Each doctor reported good access to a regular training programme, and they all reported they would recommend the department as a good place to work to colleagues.

The department had a very strong advanced clinical practitioner (ACP) programme. The department had a budgeted establishment of 40.59 WTE ACPs for which there were no vacancies. ACPs worked autonomously but within defined parameters and supported the middle grade medical rota. There was a strong presence of ACPs noted during the inspection; they appeared as a pivotal role within the department. ACPs were well respected by doctors and nurses alike.

Is the service responsive?

Requires Improvement 

Access and flow

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

Managers monitored waiting times and whilst they worked to make sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets, this was not always possible.

Front line staff reported they were on operational pressure escalation level (OPEL) three at the time of the inspection. OPEL provides a nationally consistent set of escalation levels, triggers and protocols for hospitals and ensures an awareness of activity across local healthcare providers. Escalation levels run from OPEL one; the local health and social care system capacity is such that organisations can maintain patient flow and are able to meet demand within available resources through to OPEL four; pressure in the local health and social care system continues to escalate, leaving organisations unable to deliver comprehensive care.

Urgent and emergency services

There were systems in place to manage the flow of patients through the ED to discharge or admission to the hospital however these processes did not always deliver the appropriate outcome. Staff reported the number of patients attending the department each day was increasing exponentially. This increase in activity placed extreme strain on an already fragile urgent and emergency care pathway. Extended waits to be seen for an initial assessment, and subsequent delays in clinical assessment and treatment by a doctor were listed as impacts on what was categorised as a significant risk.

Departmental over-crowding had been placed as a risk on the departmental register in December 2020. Whilst there was a range of mitigations listed against the risk, the overall adequacy of the risk was listed as 'inadequate'. This married with the views of frontline clinicians and managers.

We observed the majors waiting room was consistently over capacity which impacted on the ability of staff to encourage social distancing. We observed frail elderly patients being managed on trolleys in non-clinical areas as has already been reported in the safe domain. Staff felt a high level of fatigue and an element of loss of professionalism when providing care and treatment to patients in communal areas and having to explain to patients the reasons why they were being cared for in a communal area. Staff spoke of 'moral injury' to the workforce because of poor departmental flow and the impact it had on their ability to provide high quality, effective care.

The department had access to a sophisticated suite of metrics which detailed activity and length of stay for patients accessing urgent and emergency care. Staff described a worsening picture as the country exited Government imposed lock-down measures. For example, for the week beginning 4 January 2021, 60 patients experienced delays of more than 12 hours in the ED whereas for the week of 19 July 2021 this had increased to 248 patients. The number of attendances (by week) increased from 2,426 to 4,088 over the respective dates referred to above.

Between 16 July and 28 July 2021, the department reported 74 patients experienced a delay of 12 hours or more from a decision to admit being made and the patient being transferred to an in-patient bed. The longest wait was recorded as 21 hours and 44 minutes with a lack of admitting capacity being recorded as the reason for the delay.

High attendances, poor patient flow through the department and limited primary care access were all listed as reasons as to why the department was overcrowded. Some staff hypothesised the lack of chronic health management was also a contributory factor as to why more patients were accessing emergency care, and often with increased acuity than had been seen prior to the covid-19 pandemic. Staff felt trust wide escalation protocols were not fit for purpose as they did little to decompress the emergency department. A trust-wide standard operating procedure (SOP) existed and detailed the actions taken by specific individuals during times of surge. Staff in the ED were not satisfied with a range of the mitigations within the SOP. This included the nursing of patients in communal areas. They considered the increased nurse: patient ratio was a contributory factor which led to complaints and incidents occurring. Further, staff were highly anxious about the lack of privacy and dignity afforded this cohort of patients. We observed staff working hard to meet the needs of patients but also acknowledged the challenging circumstances in which they were working.

Staff in the ED believed over-crowding was perceived as a local department issue and was not something that was owned or managed by the wider hospital. Staff spoke of challenges with patients remaining in the ED for extended periods of time because speciality teams refused to accept patients. We observed one case in which a patient presented with back pain. They had remained in the department for over fifteen hours because the initial referral to the spinal team had been refused. A referral to the medical team was also refused and so escalation to the ED Consultant in charge resulted in the patient being referred to the spinal team. Staff reported this as a common problem and describe a culture of "Patient ping-pong". This type of behaviour had a direct impact on not only the patient who was being refused

by multiple specialties but also on patients waiting to be seen, as well as patients in the community who were waiting for ambulances to be conveyed to them. We reported our concerns to the executive team who reported new initiatives to drive improved working relationships and ownership of patients in order to not only enhance the quality of care patients received but to also aid decompressing of the emergency department and wider urgent care pathway.

Is the service well-led?

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.

The local management team were experienced and knowledgeable individuals. They were able to eloquently describe the risks and challenges faced by the service but also spoke with passion about not wanting to accept the status quo. Focus was placed on protecting staff from the challenges of working in an environment as demanding as emergency care, and during times of unprecedented demand. Leaders acknowledged improvements were required in areas including the time it took for patients to be initially assessed but implementation of plans was perhaps not always as timely as they could have been. Performance against the time to be initially assessed was seen to be deteriorating over a period of time and was showing little sign of recovery and so a more proactive approach could have resolved the issue without intervention from the regulator. However, it is acknowledged relational difficulties existed between the local management team and the upper tiers of management, including the executive team.

Local leaders spoke of an executive team who were neither present or visible and therefore could not fully appreciate the challenges staff and patients in the emergency department were experiencing. Some considered a ‘top-down’ or ‘done-to’ leadership style which hindered the ability of the local team to respond and react in the right way. Others reported that despite changes being instructed from those working outside the department, the ability of the local team to adapt and change was commendable.

Junior staff described a management team who were open, approachable and transparent. Leaders were held in high regard and were considered as champions for advocating for patients. All staff groups described an element of frustration with flow challenges as these had a direct impact on the quality of care which could be afforded by patients.

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.

Despite the challenges associated with managing the current pandemic, local leaders had considered the needs of the population and worked with other agencies in an attempt to improve patient care. Significant focus was placed on investing in staff to ensure they were sufficiently competent and capable, thus enhancing the quality of the service they could provide, and to better improve the experience for patients. The department had a comprehensive strategy titled “ED23”. Although in draft format and at a stage of consultation with staff, the strategy was detailed and set out 15 separate objectives aimed at improving services over the next two years.

Urgent and emergency services

- Leadership and Management
- ED Workforce
- Education, training and continuous learning
- New starters
- Retention
- Quality and Governance
- Environment and equipment
- Partnership working
- Innovation and potential
- Maintaining health and wellbeing at work
- Data and analytics
- Digital
- Prevention/Health Improvement
- Ethos
- Sustainability

ED23 was not only focussed on the needs of patients, but also acknowledged the requirement to invest in the workforce. This suggested there existed a clear understanding or the synergy between the investment of staff and the direct impact this has on the quality of care afforded patients and service users across healthcare. The vision and strategy were aligned to the identified risks of the department including workforce, environment, increasing patient demand and patient acuity, whilst also building on strong foundations associated with research, professional development and planning for the future.

Culture

At a local level, staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear. However, there were apparent cultural challenges and examples of poor system working with teams outside of the urgent and emergency care service.

Each year, all NHS staff are invited to complete a staff survey. The last survey was carried out in September 2020. As part of this inspection, we asked the trust to provide us specifically with the free comment texts provided by staff as these often provide a rich resource which describes the views of staff working in the NHS. The trust provided us with all free text comments made by staff working in the ED. These responses were anonymised. The vast majority of comments related to how the organisation and wider NHS had managed the pandemic which started in January 2020 and so this was taken in to account when interpreting the comments. For example, some staff raised concerns about the use of personal protective equipment. However, changes to clinical practice including the right levels of personal protective equipment were often driven by subject matter experts at a national level and often changes to practice were recommended in quick succession.

Free text comments included positive, neutral and negative feedback. Staffing levels were a major theme through the free text, often with staff asking for additional staff. Improved facilities associated with more clinical space or improved patient flow were also noted. Thirdly, support for staff and improved communication were also referenced across the commentary. 64 positive comments were made and generally detailed teamwork, the quality of patient care and staff support.

Senior local leaders were conversant with the results of the staff survey and reported 'no surprises'. The feedback was generally consistent with relevant risks which were recorded on the departmental risk register. This suggested the local leadership team were a-tuned to the views and feelings of the local team.

As has already been reported in the responsive domain, there was a perception teams working outside of the urgent and emergency care pathway were not always acting in the best interest of patients. Some staff spoke of specialties working in a "territorial" way and refused to accept referrals from the ED. More concerning, staff described a 'toxic' and 'unpleasant' cohort of staff who worked against the emergency care system, thus impacting on the quality of care afforded to patients. We raised this with the trust following the inspection.

In response to our concerns the trust responded by stating "As an organisation we have had a '10 principles' policy for a number of years; however, this has clearly lost impact and meaning. We have agreed an initiative to be launched on 2 August titled 'Just Say Yes fortnight' which will support specialties to accept ED Consultant decisions whilst monitoring the downstream impact to provide evidence to counter any myths about 'unintended consequences' - this will be either through review in ED, direction to one of our assessment locations or admission to ward. The specialty will then be responsible for onward referral if required."

The actions proposed by the trust appeared to be reasonable and have been interpreted to suggest ED consultants will be empowered to make decisions for patients in order that their care and treatment could commence without the risk of further delays. We acknowledged the 10 principles referenced in the trust response which were aligned to the concept of professional standards. However, it is of some concern the issue of poor adherence to professional standards and inter-speciality working, whilst reported at a local level of the ED leadership team and more junior staff, this issue itself had not been escalated through the divisional and executive leadership team. This suggests an element of poor information flow and/or escalation across the organisation's governance processes.

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 urgent and emergency care service sought reassurance through various governance meetings such as the ED quality and governance meeting and mortality and morbidity meetings. Minutes of the local ED governance and quality meeting were then escalated to the divisional quality meeting for consideration and action where necessary.

The ED governance and quality meeting was held monthly and attended by the leadership team and MDT staff. We reviewed the most recent minutes from the ED governance meeting. There was general good attendance and attention was payed to the standard agenda.

Urgent and emergency services

Consideration was given to incidents, serious incidents, complaints, patient experience, patient safety alerts and departmental and strategic risks. There was evidence of detailed scrutiny of incidents and patient outcomes. External subject matter experts including members of the trust sepsis team were asked to present findings of audits in order improvement opportunities could be identified and implemented. Incident action plans were reviewed to ensure progress continued to be made.

Management of risk, issues and performance

Leaders and teams did not always manage performance effectively. They identified and escalated relevant risks and issues but had failed to act on these in a timely manner. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The issues and risks identified through the inspection were generally well known amongst local leaders. However, issues surrounding patient flow, over-crowding, speciality working, and professional standards were rarely referenced in the minutes. The structure of the ED quality governance meeting allowed an opportunity for risks to be escalated to a divisional level. However, between April and July 2021 no items were marked as requiring escalation to the divisional quality board; this was a missed opportunity for the local ED team to formally raise the concerns they raised with the CQC inspection team.

A review of the local risk register suggested risks were updated frequently. The department had two risks listed as significant and were associated with overcrowding and medical staffing. The risk associated with over-crowding was reported on the wider trust significant risk register and was logged as green. That is, all proposed actions were on track. However, performance against all flow metrics associated with the emergency care pathway were seen to be on a deteriorating trajectory from March 2021 with little or no sign of recovery. Taking in to account the increased demand placed on the emergency care pathway and the impact this had been having on performance, it would have been appropriate to consider all available metrics and to escalate potential risks to the a divisional level and subsequently to the quality and assurance committee, by exception, in order that the board was fully sighted on the challenges.

At the April 2021 board, reference was made to a marginal deterioration in ambulance handover delays but that compared to benchmarked groups, this remained good. A report from the Quality and Safety Committee also noted 12-hour trolley breaches but no further reference was made to wider ED performance metrics. This is likely due to the fact the integrated performance report only referenced ambulance handover delays and 12-hour trolley breaches and did not consider any other ED metrics used to measure quality and safety.

Although there was some more in-depth discussion at the June 2021 trust board in regard to twelve hour trolley breaches and increased activity, there was again a missed opportunity for the trust board to fully analyse contributory factors and to consider the implications of increased activity against patient safety and quality of care provided.