Care Quality Commission

Sheffield Teaching Hospitals NHS Foundation Trust

Northern General Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

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

We did not inspect the GP out of hours collaborative as part of this inspection.

Overall, we rated Northern General Hospital as good. We rated safe, effective, caring and responsive as good. Well-led was rated as requires improvement.

We rated critical care and outpatients and diagnostics as outstanding. Medical care and surgery were rated as good. Emergency and urgent care and end of life care were rated as requires improvement.

Our key findings were as follows:

- We found the hospital was clean and staff adhered to infection control principles. The trust scored 99% for cleanliness in the patient-led assessments of care environments (PLACE) report for 2015.
- There was a trust infection control accreditation programme in place. This programme set standards for infection prevention and control practice. Most clinical areas had achieved accreditation; plans were in place where this was not the case.
- There had been four cases of MRSA reported by the trust between June 2014 and June 2015.
- There had been 33 cases of C.difficile between April 2015 and November 2015 at the Northern General Hospital. This was a rate in line with the England average per 10,000 bed days. The trust's rate of C.difficile was below the trajectory target with 42 cases against a stretch target of 52 cases at the end of November 2015.
- The trust used the safer nursing care tool, professional judgement and nursing hours per patient day to determine appropriate levels of staffing. There were some areas where staffing fell below planned levels on a regular basis, particularly in the Emergency Department, although the trust was mitigating risks as far as possible. Recruitment to vacancies was in progress. Staff were able to use bank or agency staff, where available, to fill staffing shortfalls.
- The trust was committed to the development of advanced nurse practitioners to ensure patient care was maintained and the potential recruitment difficulties to junior doctor posts mitigated. This also allowed good advancement opportunities for nurses.
- Mortality indicators showed no evidence of risk.
- Patients were assessed for their nutritional needs. The trust had introduced HANAT (hydration and nutrition assurance toolkit) to encourage good nutrition and hydration best practice in the hospital environment.
- There was a well-established culture of continuous quality improvement. This was supported and assured by robust governance, risk management and quality monitoring. The trust used a Microsystems Coaching Academy which worked well to support small scale service improvements.
- The trust's vision and values were embedded in practice. These informed performance reviews and staff felt they were meaningful.
- Clinical directorates had individual five year strategies that were linked to trust's strategy, aims and objectives. The directorate strategies had consideration of the other clinical departments they worked with to deliver high quality care and the assistance required from corporate directorates and other partners.
- There were concerns regarding the emergency department at the Northern General Hospital this included the clinical decision unit. Specifically we had concerns regarding the quality of care of patients during times when the department was busy.
- There were concerns regarding the clinical decision unit specifically regarding the monitoring and escalation of deterioration patients in the seated area of this unit. We raised this with the trust at the time of inspection and a protocol was put in place.

Summary of findings

- The introduction of a new IT system had resulted in the trust not being able to record performance targets in the emergency department.
- There were variable levels of compliance with mandatory training.
- There was variation in the quality and completeness of Do Not Attempt Resuscitation (DNACPR) forms.
- In medicine, there were concerns regarding the access to nursing guidelines that were held electronically and could not always be accessed by all nursing staff. Care needs were conveyed between nurses using verbal communication or handover sheets rather than referring to the nursing care plan.

We saw several areas of outstanding practice including:

- The patient care and experience delivered by staff in the Bev Stokes Day Surgery Unit, particularly in relation to patients living with learning disabilities and dementia, was outstanding.
- The duty floor anaesthetist role in theatre developed in Sheffield was going to be used by the Royal College of Anaesthetists as a beacon of good practice.
- A relative's room had been developed within the operating theatre complex.
- On GICU /GHDU, there was the use of an electronic patient information system to ensure timely and accurate records, access to trust and local policies, procedures and guidelines The system ensured effective care was delivered and it was fully integrated and provided real-time information across teams and services.
- An advanced clinical pharmacy service which included a consultant pharmacist and pharmacy prescribers had been developed to improve the safety and efficacy of medicines used in critical care.
- The use of the Enhanced Recovery After Thoracic Surgery (ERAS) programme had resulted in marked improvements in the quality of care for patients on CICU.
- The laboratory team had introduced a 'Patient Safety Zone' project into the inpatient wards and in the community. The aim was to reduce labelling errors. Disturbance or distraction while taking blood samples has been identified as a major risk factor for errors. This initiative had been introduced to improve patient safety. Pathology staff showed us lots of publicity material, including branded biro pens.
- In laboratory medicine, we observed large screens above the bench dealing with urgent samples. It contained a full list of patients waiting for results in the emergency department. The same screens were on display in the emergency department. This meant laboratory staff could see exactly who was waiting in the emergency department and gave context and 'humanity' to the samples they were analysing. Urgent results for the emergency department samples were available in one hour because of the use of this management tool.
- Radiology provided an excellent service of 'hot reporting' for reporting x-rays for the emergency department patients; results were ready within 20 minutes.
- There were numerous examples where staff went out of their way to meet individual's needs. Staff demonstrated acts of kindness and flexibility to ensure patients and families suffered as little distress as possible.
- A culture of innovation and improvement was evident throughout all levels of the organisation. For example, geriatric medicine had historically been part of acute medicine but was now combined with community services. It was hoped this would help improve integrated pathways for elderly patients between acute and community services and facilitate provision of services in the community to enable elderly patients to be cared for at home whenever possible.

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

Importantly, the trust must:

- The trust must ensure patients do not wait longer than the recommended standard for assessment and treatment in the emergency department.
- The trust must ensure that on initial assessment in the "pit stop area" in the emergency department patient's vital signs are taken and recorded consistently.
- The trust must ensure that patients in the clinical decisions unit have timely clinical reviews.

Summary of findings

- The trust must monitor performance information to ensure 95% of patients are admitted, transferred or discharged within four hours of arrival in the emergency department.
- The trust must ensure robust escalation processes are implemented in the emergency department.
- The trust must ensure arrangements for governance within the emergency department operate effectively.
- The trust must ensure the safe storage of intravenous fluids.
- The trust must ensure doctors follow policy and best practice guidance in relation to the prescription of oxygen therapy.
- The trust must ensure a strategy for end of life care is implemented.
- The trust must ensure that DNACPR records are fully completed.

In addition the trust should:

- The trust should ensure that staff have attended mandatory training in accordance with the trust target.
- The trust should improve the compliance rates for medical and nursing staff receiving an annual appraisal.
- The trust should implement plans to increase nurse staffing in the emergency department to ensure there are appropriate staffing levels at all times.
- The trust should continue to review the provision of 24 hour consultant medical cover within the emergency department as part of being a major trauma centre.
- The trust should review and implement standards of record keeping, risk assessments and the documentation of care given in the emergency department so staff have the complete information they require before carrying out care and treatment.
- The trust should continue to take action to ensure the emergency department achieve the recognised standard of 15-minute arrival by ambulance to handover to emergency department.
- The trust should review guidance in the emergency department to ensure it reflects current evidence-based guidelines.
- The trust should review the experience of patients to ensure privacy and dignity is maintained in the emergency department, particularly during busy periods.
- The trust should ensure staff follow policy and best practice guidance in relation to the administration of intravenous fluids.
- The trust should review the use of nursing care guidelines and ensure they are consistently available for all staff providing patient care, to enable accountability for care provided.
- The trust should try to reduce the movement of staff to clinical areas outside of their speciality.
- The trust should introduce a robust process to share lessons learnt from incidents and mortality and morbidity reviews across directorates and care groups.
- The trust should ensure it reviews the process for the appropriate testing of all medical equipment used for patient care in the critical care units.
- The trust should ensure that there are appropriate weaning plans in place for all patients with tracheostomies and that these are made in timely way.
- The trust should consider reviewing review data collection methods and the process for submitting ICNARC data for Cardiac Intensive Care, so that patient outcomes can be benchmarked with other similar services.
- The trust should consider reviewing the critical care services in line with the Core Standards for Intensive Care Units 2013 to address areas where they are not meeting these standards.
- The trust should consider reviewing the computer provision on CICU.
- The trust should consider the implementation of the electronic patient clinical information system on CICU so there is alignment with the other critical care units.
- The trust should consider a process for obtaining patient feedback following discharge from critical care.
- The trust should monitor preferred place of care for patients at the end of life.
- The trust should review implementation of NICE urinary incontinence in neurological disease for outpatients in the spinal injuries unit.

Summary of findings

- The trust should review the fracture clinic environment to ensure meet the needs of patients.
- The trust should routinely collect waiting time information for patients waiting for appointments.
- The trust should develop standard procedures for completing interventional radiology non-surgical safety checklists for all staff to follow.
- The trust should consider undertaking regular audits of patient electronic records to ensure consistency in the completion of MRI safety checklist and pregnancy checks.
- The trust should continue to take action to reduce the number of medical outlier patients across the trust.
- The trust should continue to take action to reduce the number of bed moves patients experience during their hospital stay.
- The trust should monitor access to records in the outpatient departments.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	Patients often waited longer than the recommended standard for assessment and treatment. Patients did not always have a positive experience whilst in the department due to the flow and overcrowding within the department. New pathways had recently been developed to improve the access and flow within the department. Planned nurse staffing levels were not always achieved. A staffing review had been undertaken, the outcome of which was to increase nurse staffing levels however, these staff, were not in post at the time of the inspection. The department met the standard for emergency department to admit, transfer or discharge 95% patients within four hours of arrival on average for 90.3% of occasions between September 2014 and September 2015. On some occasions patients waited in the department for longer than 12 hours from attendance. The emergency department did not consistently achieve the recognised standard of 15-minute arrival by ambulance to handover to emergency department. The department was unable to provide data, or confirm accuracy of data, to report on performance activity in the emergency department since the implementation of a new computer system on the 28 September 2015. Standards of record keeping were variable. Care and treatment provided did not always reflect current evidence-based guidelines. The arrangements for governance did not always operate effectively. The departmental risk register did not include some of the issues found on inspection including the use of CDU, escalation of deteriorating patients or the TARN peer review outcome and it did not show when the risks were last reviewed, or any actions taken to minimise the risk.
Medical care	Good 	

Summary of findings

(including older people's care)

Surgery — **Good**

Directorates had clear strategies driven by quality and safety aligned to the trust's vision and values. Systems and processes for infection control, medicines management and patient records were mostly reliable and appropriate to keep patients safe. Staffing levels and skill mix were planned and reviewed to keep people safe. Staff recognised and responded promptly and appropriately to risks and deteriorating patients, including overnight and at weekends. There was limited evidence of learning from incidents across directorates at ward level.
Care and treatment was planned and delivered in line with evidence based guidance and best practice. Since July 2013, the trust's RTT performance had generally been below the trust's 90% standard for the admitted RTT target. However, the trust overall performed better than the England average from October 2014 to May 2015.
Staff treated patients with dignity and respect and maintained their privacy.

Critical care — **Outstanding**

Performance showed a good track record and steady improvements in safety. Staffing levels and skill mix were planned and reviewed to keep people safe. Systems, processes and standard operating procedures for infection control, medicines management, patient records and the monitoring and assessing and responding to risk were mostly reliable and appropriate.
Patients had comprehensive assessments of their needs. Staff worked collaboratively to understand and meet the range and complexity of patient's needs. Staff were qualified and had the skills they needed to carry out their roles effectively.
Information about patients care and treatment, and their outcomes, was not routinely collected or monitored in within the cardiac intensive care unit therefore the service was unable to benchmark itself against other similar services.
Patient's emotional and social needs were highly valued by staff and were embedded in their care and treatment. Feedback from patients who used the service was continually positive about the way staff

Summary of findings

treated them. There was a strong, visible patient centred culture. Services were tailored to meet the needs of the individual patient. There was a proactive approach to understanding the needs of different groups of people.
Leaders prioritised safe, high quality person-centred care. There was a clear statement of vision and values, driven by quality and safety. There was a strong focus on continuous learning and improvement.

End of life care	**Requires improvement**		We found do not attempt cardiopulmonary resuscitation (DNACPR) decisions were not always made in line with national guidance and legislation. The trust did not monitor if patient choice around preferred place of care or death was met. There was no internal strategy in place for end of life care at the trust. In response to the 2013 review of the Liverpool Care pathway, the trust had produced guidance. However, this had not been made available until October 2015. However, we also found patients received safe care and treatment which met their needs. The specialist palliative care team of nurses and doctors were skilled and knowledgeable. There was a specialist palliative care unit, staffed by a skilled team Care was led by consultants and a range of staff responded to patient needs. In the year from April 2014 to April 2015, over 97% patients were seen within 24 hours of referral to the specialist palliative care team. There was seven day cover from the team. There was evidence of compassionate and understanding care on all the wards at the hospital. There were positive examples of local leadership on the Macmillan Palliative Care Unit (MCPU) and in the palliative care team from both a nursing and medical perspective.
Outpatients and diagnostic imaging	**Outstanding**		The services had a positive safety culture; there were clear management responsibilities and accountability for safety and governance. The services promoted continuous quality improvement. There were enough qualified, skilled and experienced staff to meet people's needs. Staff received good support, staff appraisals, and mandatory training was up to date. Radiology

Summary of findings

services provided well-established, highly regarded training programmes for medical staff at every stage of their five-year programme and for student radiographers from local universities.
All of the staff were passionate about their work and staff teams worked well together to provide an excellent experience for their patients. All of the patients and relatives we spoke with gave positive feedback about the staff, care and the treatment they received.
Space was limited in the fracture clinic and was not designed to meet the needs of patients.
Staff were aware of the trust values; there was good staff engagement and an open culture. Staff participated in research activities and there were numerous examples of innovation and improvement.

Northern General Hospital

Detailed findings

Services we looked at
Urgent & emergency services; Medical care (including older people's care); Surgery; Critical care; End of life care; Outpatients & Diagnostic Imaging

Detailed findings

Contents

Background to Northern General Hospital

The Northern General Hospital has over 1100 beds and employs more than 6,000 staff. It provides a wide range of specialist services including orthopaedics, renal, heart and lung services and has a purpose built spinal injuries unit. There are a general and cardiac intensive care services onsite.

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

Our inspection team

Our inspection team was led by:

Chair: Professor Stephen Powis, Medical Director

Head of Hospital Inspections: Amanda Stanford, Head of Inspection

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

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team inspected the following six core services at Sheffield Teaching Hospitals NHS Foundation Trust:

- Urgent and emergency care
- Medical care (including older people's care)
- Surgery
- Critical care
- End of life care

Detailed findings

• Outpatients and diagnostics

Before the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the hospitals. These included the clinical commissioning group (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), royal colleges and the local Healthwatch.

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

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

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

Facts and data about Northern General Hospital

The accident and emergency department at the Northern General hospital saw 118,326 attendances September 2014 to September 2015. In 2014, attendances above the age of 17 accounted for 98.6% and 1.4% were under 16, this is due to a local dedicated children's emergency department being available in the city. Nineteen percent of all attendances resulted in an admission to hospital. There was an average of 324 attendances per day. An average year on year increase in attendances had been seen from 9,533 attendances per month April 2012 to March 2013 to 9,974 attendances per month April 14 to August 15.

Between January and December 2014 there were 31,100 surgical episodes of care carried out at NGH. Between July 2014 and June 2015, there were 307106 OP appointments at the Northern General Hospital.

The population of Sheffield have a health and life expectancy are generally worse than the England average including the rate of hospital stays due to drug and alcohol related harm; smoking related deaths; teenage pregnancy and a higher than average mortality rate in the under 75 age group for cardio-vascular and cancer disease. Smoking rates and adult obesity are slightly worse than the England average

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

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	☆ Outstanding	☆ Outstanding	Good	☆ Outstanding
End of life care	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	☆ Outstanding	☆ Outstanding
Overall	Good	Good	Good	Good	Requires improvement	Good

Notes

Urgent and emergency services

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

Information about the service

Northern General Hospital is part of the Sheffield Teaching Hospitals NHS Foundation Trust. The accident and emergency department provides emergency treatment to the population of Sheffield and surrounding areas. It is also one of the three major trauma centres within Yorkshire and accepts emergency admissions from within the region. The South Yorkshire major trauma operational delivery network serves a total of 1.6 million of which 375,000 are under the age of 16 years. One major trauma centre is available in the area on two sites. Northern General Hospital for adult admissions and Sheffield Children's Hospital for paediatric trauma admissions.

Two NHS ambulance services provide cover to the area; Yorkshire Ambulance and East Midlands Ambulance. The accident and emergency department had 35 majors and minor treatment cubicles: eight resuscitation bays, including one paediatric resuscitation, two rooms were used for the triage and initial assessment of patients attending the department, two cubicles were available for rapid assessment of admissions arriving via ambulance and a mental health assessment room.

The layout of the department was two major treatment areas (blue and red), one minor treatment area, a rapid assessment area and a large resuscitation area. Adjacent to the department was a clinical decision unit providing 11 cubicles and a 26 seated waiting area. Patients had treatment in one of the areas depending on the severity of their presenting condition. Two relative's rooms were available for relatives to wait in and a viewing room in a quiet area to view deceased patients. The accident and emergency department at the Northern General hospital saw 118,326 attendances September 2014 to September 2015. In 2014, attendances above the age of 17 accounted for 98.6% and 1.4% were under 16, this is due to a local dedicated children's emergency department being available in the city. Nineteen percent of all attendances resulted in an admission to hospital. There was an average of 324 attendances per day. An average year on year increase in attendances had been seen from 9,533 attendances per month April 2012 to March 2013 to 9,974 attendances per month April 14 to August 15.

During our inspection, we spoke with 40 members of staff including receptionists, nurses, doctors, domestics and paramedics, 26 patients and four relatives or carers. We reviewed 58 sets of records and a range of performance information about the emergency department.

Urgent and emergency services

Summary of findings

We rated the emergency department at Northern General hospital as requires improvement overall because:

- Patients often waited longer than the recommended standard for assessment and treatment. When the department was crowded and very busy, we had concerns about the consistency, and staff's understanding of escalation systems. When staff did escalate, robust support mechanisms were not always apparent.
- Staff had difficulties in protecting and maintaining patient's privacy and dignity and confidentiality. Due to the overcrowding within the department, patients were often nursed directly next to another patient, or adjacent to another patient's curtains or in an inappropriate area such as a hospital corridor. Patients did not always have a positive experience whilst in the department due to the flow and overcrowding within the department.
- We witnessed and reviewed nurse staffing rotas and noted frequent periods of nurse understaffing. At these times, the trust redeployed staff from other areas or agency staff were requested, however established staffing levels were not always achieved. When shift vacancies were filled, many different agency staff were used. A staffing review had been undertaken, the outcome of which was to increase nurse staffing levels however, these staff, were not in post at the time of the inspection.
- There were no on-site consultants in emergency medicine available between midnight and 8am.
- The department was unable to provide any data, or confirm accuracy of data to report on performance activity in the emergency department since the implementation of a new computer system on the 28 September 2015. The department only met the standard for emergency department to admit, transfer or discharge 95% patients within four hours of arrival on average for 90.3% of occasions between September 2014 and September 2015. On some occasions patients waited in the department for longer than 12 hours from attendance.
- The emergency department did not consistently achieve the recognised standard of 15-minute arrival by ambulance to handover to emergency department.
- Standards of record keeping were variable, risk assessment and documentation of care delivered was not always available, because of this staff, did not always have the complete information they require before carrying out care and treatment.
- Pathways and guidelines we reviewed had variable compliance with National Institute for Health and Care Excellence (NICE) guidelines and the College of Emergency Medicine (CEM) clinical standards for emergency departments. There was participation in national and local audits, however performance was variable and when poor performance was highlighted timely action was not taken to improve patient outcomes.
- The arrangements for governance did not always operate effectively. The departmental risk register did not include some of the issues found on inspection including the use of CDU, escalation of deteriorating patients or the TARN peer review outcome and it did not show when the risks were last reviewed, or any actions taken to minimise the risk.

Areas of good practice we witnessed:

- A positive awareness by all staff of the impact an overcrowded department and poor flow can have on patient experience. As a consequence, services had been reviewed, and new pathways developed to improve the access and flow within the department. The recommendations from the review had only recently been implemented so the full impact of the changes had not yet been achieved.
- Patient's nutrition and hydration was a priority due to the introduction of an emergency department housekeeper and hydration rounds had improved patients access to food and drinks.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

Following the inspection we have rated the emergency department at Northern General hospital as requires improvement because:

- Patients often waited longer than the recommended standard for assessment and treatment. When the department was crowded and very busy we had concerns about the consistency, and staff's understanding of escalation systems. When staff did escalate, robust support mechanisms were not always apparent.
- We observed that patients remained in the clinical decision unit for too long, in some cases over twelve hours from the time of admission, with long periods between clinical review, there was also a lack of adherence to pathways for the unit and the ratio of staff to patients was too small.
- On initial assessment in the "pit stop area" patient's vital signs were not taken or recorded consistently, ambulance recordings were often documented as the first set of observation.
- We witnessed and reviewed nurse staffing rotas and noted frequent periods of nurse understaffing, agency bookings were made, however stablished staffing levels were not always achieved. When shift vacancies were filled, many different agency staff were used. A staffing review had been undertaken the outcome of which was to increase nurse staffing levels however, these staff, were not in post at the time of the inspection.
- There were no on-site consultants in emergency medicine available between midnight and 8am.
- Standards of record keeping were variable, risk assessments and the documentation of care given was not always documented, because of this staff, did not always have the complete information they require before carrying out care and treatment.
- In the resuscitation area we saw there was frequent non-recording of the dosage given of controlled drugs in the controlled drug book, the cupboard containing anaesthetic drugs was not locked and fridge temperature records were incomplete.
- Resuscitation equipment used in the main department was not consistently checked. Records of checking were not always available.

Areas of good practice were noted in the shift handover procedures, sharing of messages and learning via fortnightly focus, major incident training and the departmental induction of newly qualified nurse

Incidents

- There had been no never events in the department in the reporting period August 2014 to July 2015.Never events are serious incidents, which are wholly preventable as guidance and safety recommendations are available that provide strong systemic protective barriers at a national level.
- Serious incidents are incidents that require further investigation and reporting. One serious incidents (SI) was reported within the emergency department in the reporting period August 2014 to July 2015. This incident involved a drug error, which we discussed with the senior management team we reviewed this report and found evidence of actions taken and lessons learnt,
- Prior to the inspection we were sent incident data from April - August 2015. This indicated that the department reported no incidents resulting in severe harm, death or abuse. There were 117 incidents, which were graded as moderate (1), minor (71) and insignificant harm (45). Themes from these incidents included pressure ulcers and discharge issues. During the inspection we were given data that indicated 356 incidents were reported in quarter two 2015 (July to September). It was unclear why the number of reported incidents had risen.
- There was a process for senior nursing and medical staff to review the incidents reported and analyse the data to identify trends, monitor actions and learning. The top three categories of incidents reported was pressure ulcers (127/356), general care (66/356) and slips, trips and falls (43/356). Staff spoke to us about drug errors being a theme in the previous year and the changes in practice they had put in place to stop these from occurring. Examples of change in practice due to learning from clinical incidents was the decision to stop verbal orders for medications throughout the department and the development of a flow chart for patients where a blood clot in the lung was suspected; this flow chart replaced a 40 page pathway document.

- Staff could describe their roles in relation to the need to report, provide evidence, take action or investigate as required. Staff did however report that they did not complete an incident form on every occasion required due to workload; they also said that they did not always receive any feedback on incidents when they did report them. Senior nursing staff were aware of the issue, and had tried to provide individual feedback, however the decision to not provide individual feedback was made external to the department, due to confidentiality issues.
- Discussion of incidents and SIs were held at the emergency department governance meeting, trauma governance meetings and informal debrief sessions. Staff told us that sharing of learning from incidents occurred internally through incident newsletters, debrief sessions, emergency department governance newsletters and fortnightly focus themes. Following some incidents for example, drug errors, practical and competency-based education was available on a one to one basis. Nurses involved in incidents were support by one of the nurses from the governance team.
- A private link corridor within the department provided an area to share messages and information with staff. This area had information displayed for incidents, governance newsletters IPC, major trauma, clinical governance, training events, research papers and mental health.
- The senior management team told us about a current backlog in incident investigation and closure, with approximately about 30 incidents requiring investigation. An additional nurse was seconded into a departmental clinical governance role to improve timeliness of investigation and closure. Staff working within clinical governance showed us the process of reviewing new incidents and it was clear that although the incidents remained open, staff had oversight of all incidents and prioritised them.
- Regular mortality and morbidity meetings were held to discuss cases and share and learn from incidents within the department. We reviewed two sets of major trauma monthly morbidity and mortality meetings; good attendance of the multidisciplinary team was noted. Probable survival rates, patient outcomes, actions and examples of good practice were recorded.

Duty of Candour

- All staff we spoke to were all aware of duty of candour requirements and described it as being "open and honest" when incidents occurred. Staff provided us with examples about its use. Records of duty of candour discussions were documented on the central incident reporting system.

Safety thermometer

- The NHS safety thermometer is a nationally recognised NHS improvement tool for measuring, monitoring and analysing patient harms and 'harm free care'. It looks at risks such as falls, pressure ulcers, venous thrombolysis (blood clots), and catheter and urinary tract infections (CUTIs).
- In the reporting period, July 2014 to July 2015 there had been no reported pressure ulcers grade two, three or four, falls or catheter related urinary tract infections (CAUTI) reported in ED. Incident forms were completed if patients developed pressure damage.
- While the incidence of pressure ulcers was not elevated, we did observe a patient during the inspection that had developed pressure damage due to increased length of stay in the department.

Cleanliness, infection control and hygiene

- The infection prevention and control (IPC) team delivered training both face to face and via e learning. IPC training compliance rates for the emergency department were 73% September 2015 which was lower than the trust target of 90%.
- Departmental audits of infection prevention and control principles were undertaken. Data we reviewed from October 2014 to September 2015 showed 100% compliance with aseptic technique, on average 68% compliance was noted with commode cleanliness and 89% compliance with hand hygiene audits.
- Electronic audits of cleanliness and hygiene standards were undertaken in the trust. These were being completed within the emergency department the time of inspection, however, these had not been completed for the previous 33 months.
- During the inspection, we noted good availability of alcohol gel. Soap dispensers we reviewed were all in working order. During the inspection we observed staff, were mainly compliant with IPC policies, for example, the all staff we observed were bare below elbows and

personal protective clothing was used. Single rooms were available for the isolation of infectious patients. However, during the inspection a patient with an infectious disease was not isolated as appropriate.

- Within the emergency department, between April 2014 and April 2105 one-reported case of hospital acquired Methicillin resistant staphylococcus aureus (MRSA) and six reported cases of Clostridium difficile (C.diff) were reported. None of the cases of C.diff were identified as hospital acquired.
- In October 2015, the department introduced a new domestic cleaning schedule, which included weekly steam cleaning of all emergency department patient trollies. Environmental cleaning schedules were available and displayed in public areas. Domestic staff in the emergency department took the cue to clean a bay from the request for a porter for transfer. This ensured the bay was cleaned prior to the next patient being transferred.
- During the inspection, the department was visually clean. Internal domestic department cleanliness scores we reviewed showed levels of above 98% since May 2015.
- Equipment cleaning assurance labels provided assurance that re-usable patient equipment was clean and ready for use; however their use was sporadic. We reviewed fifteen pieces of clinical equipment and labels were used on four occasions .During our inspection two commodes had been used and were taken into the sluice area, staff did not clean or label these commodes prior to leaving the area. A poster was available in the sluice area advising staff that all commodes should be cleaned and labelled post use.
- The sluice area was accessed from a public corridor; the door was often left open. The floor was dusty, dirty and had litter present. It is good practice for cleaning products to be stored in a locked cupboard; harmful cleaning products were stored in the sluice on the worktop.
- In the A&E survey 2014, the trust performed “about the same” as other trust on the question in your opinion, how clean was the accident and emergency department.
- The decontamination area had running water; daily legionella checks were complete for running of the shower.

Environment and equipment

- The department had been designed and built in 1982; the unit had been extended in 1997, and refurbished in 2013. The resuscitation area had increased and been redesigned during this refurbishment.
- In the main waiting room, we saw damage to seven seats making them difficult to clean; this area was very drab and had little to occupy patients during their wait.
- One specific resuscitation bay was available for paediatric resuscitation. No specific paediatric minor or major treatment areas were identified. However, children were rarely seen in the department as there was a separate children’s hospital with an ED
- A dedicated room was available for the assessment of patients presenting with mental health conditions; this room was equipped with an emergency call buzzer and two points of access/exit. Due to the placement of this room, being in a very busy area of the department, staff told us that patients presenting with mental health conditions could often be placed in other areas of the department.
- A dedicated room was available for decontamination and assessment of infected/clinically contaminated patients. However, during the inspection this room was full of miscellaneous items. A business case had been prepared and agreed for improvement of this area. The work to improve this area had been due to commence in November 2015, however it had been put on hold recently due to further environmental upgrades required in the department.
- Walls in the minors area of the department were very damaged with holes present, paint missing and generally in need of repair.
- Sterile equipment was not always stored correctly in the resuscitation area. We saw evidence of sterile equipment, for example sterile airways, left open in drawers. It was not always clear whether this equipment was clean or whether it had been used. Empty packaging from sterile equipment was found in drawers and on floors. Worktops within the resuscitation area were found to be cluttered and contained vials of medicines and general packaging.
- Equipment in a central storage area was stored on shelves and in good condition. Stock we checked in this area was sealed, stored correctly and in date In the main department there were adequate stocks of equipment and we saw evidence of good stock rotation. Equipment and fluids to be used in major incidents was not stored safely, for example, two bags of intravenous fluid were

out of date and, a patient airway was found to be open on the floor. A major incident bag was available in the CDU area; this bag was very dusty and contained action plans in a folder scheduled for review in 2014.

- We observed damage to mattress trollies used for patient care; we unzipped five mattresses and noted internal staining to four. We discussed this with the governance lead. The department had recently undertaken a mattresses audit, which highlighted 41 mattresses which required replacement; the department had made a decision to replace all mattresses in the department. At the time of the inspection, the department was in the process of contacting specialist suppliers and arranging trials. Post the inspection, the trust has told us that all mattresses have been replaced. Records of daily checks of resuscitation areas were not always completed for the week prior to the inspection, a senior nurse we spoke to told us the record book had been missing.
- Resuscitation equipment used in the main department was not consistently checked. Records of checking were not always available.
- During the inspection, in one three hour period we observed patient trollies, chairs, sharps bins and wet floor signs in the middle of bays, making the area very cluttered and difficult to respond to an emergency or walk safely.
- Security staff were not available within the department 24 hours a day, staff told us that security staff were available if required, but were not based in the emergency department.
- All equipment we checked was compliant with electrical safety testing.
- At the time of the inspection major trauma patients transported via emergency helicopters landed on the hospital site but some distance away from ED and were then transferred via land-based ambulance. During the inspection we observed building work being undertaken to provide an onsite helipad to allow emergency ambulances to land adjacent to the emergency department. This helipad was due to open in spring 2016.
- A new access route had been developed to allow timely access to the CT department; patients requiring CT could now be transported in less than a minute.

Medicines

- In the main department, medicines were stored, prescribed and administered appropriately and access to medicines was restricted to authorised staff. Controlled drugs were appropriately stored with access restricted to authorised staff and accurate records were maintained. Daily balance checks of the quality of medicines were performed in line with the trust policy.
- In the resuscitation area we saw there was frequent non-recording of the dosage given of controlled drugs in the controlled drug book over the previous three months. In December 2015, this had not been recorded on 98 occasions. We also witnessed anaesthetic medication left out on a worktop and the cupboard containing anaesthetic drugs was not locked.
- Medicines fridges were secured, however temperature records were incomplete. In resus, no records had been made at all, although there was an SD card recorder on the fridge which meant that records were only reviewed if the data was downloaded onto a computer. In the minors area, temperatures had not been recorded on 14 days in November and there were no records for September or October. This meant that drugs may have been stored outside of the recommended range necessary for safety and efficacy of the medicines and that staff were not following trust policy and national guidance.
- Patient Group Directions (PGDs) were in use and there was a procedure in place to review them. PGDs are written instructions, which allow specified healthcare professionals to supply or administer a particular medicine in the absence of a written prescription. We checked a PGD used by the nursing team and saw this was being used effectively to support patient access to pain relief in a timely way.

We saw examples of learning from serious medicines incidents and subsequent changes in practice, for example we were told about changes made in the prescribing and administration of heparin.

- Hospital prescription pads were in use in the minors area and these were stored on a desktop in the assessment area. This meant that access to controlled stationery was not restricted to authorised staff. The nurse in charge moved these to a more secure location during our visit.

Records

Urgent and emergency services

- Emergency department records were prepared for each patient that attended the department, the emergency department had recently implemented a national computer patient administration programme; however paper based records were still in use.
- We reviewed 58 sets of medical and nursing care records whilst on site. They were legible and entries were all signed and dated as per trust policy.
- The department had risk assessments for falls and pressure damage prevention however, the documentation of assessment was not always available. We reviewed nine falls assessments and on five occasions, documented evidence of the assessment was not available. We reviewed 12 pressure ulcer assessments and documented evidence of assessment was available on 8 occasions. Ongoing recording of pressure care delivered was available on three out of six occasions.
- Staff we spoke with told us that a coroner had highlighted poor documentation in the emergency department records during a recent inquest. We reviewed the serious incident report and were able to confirm that lessons had been learnt and that changes in practice had occurred.
- The department used intentional rounding, to ensure patients were comfortable and all cares had been delivered. Records we reviewed showed that this was not documented on six out of 11 occasions and, when it was documented; consistently.
- Paper records were found unattended by inspection staff on departmental worktops on numerous occasions, on two occasions staff were unable to identify patient's paper records and assumed they had been misplaced and new records had to be prepared.
- Care plans for frequent attenders into the emergency department were available on the patient administration programme to allow rapid access to medical records and continuity of care.
- Information governance training compliance rates we reviewed showed compliance at 69% which was lower than the trust's target rate of 90%.
- During the inspection we saw that a record book of pregnancy tests carried out was stored in an unlocked sluice area; this document had patient identifiable data stored within it and was a potential breach of confidentiality.

Safeguarding

- A recent Care Quality Commission review of health services in safeguarding and looked after children services in Sheffield, including services provided to young people at the northern general emergency department had been undertaken. They noted "excellent examples of strong paediatric liaison", and good liaison with children and young people mental health service (CAMHS). However, they noted a city-wide reliance on telephone calls for referral concerns rather than written follow up information.
- Staff received mandatory training in the safeguarding of vulnerable adults and children as part of their induction, followed by yearly safeguarding refresher training provided by the paediatric liaison nurse. Three levels of safeguarding children's training were provided and two levels of adult safeguarding. We reviewed safeguarding training compliance rates for the emergency department and found that the levels were below the target of 90% for all five types of training. Safeguarding children being the lowest; at level one training compliance was at 78%, level two at 53% and level three at 52 %. Safeguarding adults at level one was 88% compliant and level two 81%.However the CQC's children's report noted that the training needs analysis for the trust did not accurately identify emergency department practitioners as needing level three safeguarding training.
- Staff we spoke to could describe their roles in relation to reporting and taking action when safeguarding issues were identified.
- The department had systems in place for the identification and management of adults and children at risk of abuse (including domestic violence). During the inspection, we noted compliance with the trust safeguarding policies and referrals being made to safeguarding teams and domestic violence teams.
- Senior nursing staff attended multi-disciplinary safeguarding and vulnerable adults meetings quarterly.
- Staff we spoke with were aware of assessment and reporting when required for child exploitation and female genital mutilation, this formed part of the safeguarding training. A poster was displayed on the new legal requirements of reporting female genital mutilation.

Mandatory training

- Mandatory training was delivered as face-to-face training sessions or via e-learning on an internal computer based training programme. A departmental competency based training and induction package had been developed.
- The trust target for mandatory training completion was 90% compliance. Training data we reviewed for the emergency department showed overall compliance at 76%, however variable levels of compliance was noted for individual training programmes. Compliance ranged from 55% for moving and handling and IPC, to 90% for equality and diversity. Reports of compliance with e-learning training were available directly from the system for matrons and managers to review.
- Departmental specific training data we reviewed showed that advanced life support training currently only had 18.1% of nursing staff trained, 18 further places were booked for 2016. Training leads were aware of the low numbers of staff trained to advance life support standards and told us about difficulties nursing staff have accessing this course. To compensate for this leads booked staff onto immediate life support training; records we reviewed showed that 72.5% (66/ 91 staff) of nursing staff were trained to ILS standards. This was in addition to mandatory training requirements.
- Paediatric life support training was provided. Training rates we reviewed showed 13% (14/108 staff) had completed this training, staff we spoke with said this was because the department was mainly an adult only department. Three emergency department consultants were trained in paediatric life support.

Assessing and responding to patient risk

- The receptionist initially registered patients that walked into the department. The receptionist would highlight to the triage nurse any patients they were concerned about in the waiting area; they would also categorise patients as urgent according to a set category of conditions. The receptionist observed the waiting area for signs of deterioration in patients; twice during the inspection, the waiting area was unobserved with no one available behind reception. Receptionist staff had previously highlighted their concerns over their lack of clinical knowledge and training.
- Guidance issues by the College of Emergency medicine (CEM) states a face-to face assessment should be carried out by a clinician within 15 minutes of arrival or registration. During the inspection, we observed patients waiting times, reviewed paper documentation, and noted that patients waited on average 30 minutes for triage; the maximum-recorded wait was 135 minutes and the minimum wait was 3 minutes. Three patients requiring urgent triage with chest pain and an urgent GP referral waited 12, 9 and 30 minutes respectively. One patient with chest pain waited 64 minutes for a heart tracing to be obtained. Another patient was found in the waiting room awaiting triage looking unwell this patient was noticed by the triage nurse and brought directly through to the department for treatment.
- The department used a modified recognised triage system; patient flow was identified by the use of a colour system. Once triaged, patients received an initial assessment via medical staff or emergency nurse practitioner/ advanced nurse practitioner (nurses who have undertaken additional training, which allows them to see and treat patients).
- Patients arriving via ambulance entered via a specific entrance for ambulances. Patients would be booked in by a receptionist, and be seen by an emergency department consultant (08.00 to 20.00hours) in an area called ”pitstop”. This area provided rapid assessment and initial treatment, unless their clinical condition indicated immediate access into the resuscitation bays. Patients were then taken to the correct area for further treatment.
- The “pitstop” was staffed by an emergency department consultant; no nursing staff were allocated to this area. A technician was available to carry out investigations. Patient’s vital signs were not always obtained in this area and ambulance recordings pre-attendance to the emergency department were often used as a patient’s baseline recording.
- The emergency department aimed to ensure patients who arrived by ambulance were kept waiting for no more than 15 minutes before patients were handed over from the ambulance crews to the emergency department. In the reporting period January 2013 to January 2015 the median handover, time had increased from 3 minutes to 6 minutes, which was better than the England average. Data supplied by the trust for August 2015 showed that a handover in 15 minutes from the ambulance crew arrival to the emergency department occurred on average 62% of occasions. The maximum percentage of handovers achieved within 15 minutes was 79% and the minimum being 37%. This was worse than the England average.

Urgent and emergency services

- There were 765 handovers delayed over 30 minutes between November 2014 and March 2015, the trust told us they had validated the data with the ambulance service and that this figure had reduced to 349 handover delays during the same time period.
- Black breaches occur when the time from an ambulance's arrival to the patient being formally handover to the department is longer than 60 minutes. The emergency department had 155 patients who waited over one hour in the reporting period October 2014 and September 2015. Performance was generally better than the England average performance. Seventy two percent of theses breaches occurred over the winter period of November 2014 to March 2015.
- During the inspection, we saw on a daily basis multiple ambulance crews waiting in the ambulance lobby to handover patients, on one-occasion eight different ambulance crews were waiting to handover patients. On average during the inspection, patients were waiting 21 minutes to be handed over to emergency department staff.
- In the A&E survey 2014, the trust performed about the same as other trusts on the questions about the length of time to handover from ambulance crew, time to speak to a member of nursing or medical staff and time to examination.
- The College of Emergency Medicine recommends that the time patients should wait from arrival to receiving treatment is no more than one hour. The median for patients at this hospital was less than an hour, but had been increasing since January 2013 from 30 minutes to 50 minutes in July 2015.
- During the inspection, we observed patients waiting to see a doctor and reviewed paper documentation. We saw that patients waited on average of 135 minutes; the maximum-recorded wait was 337 minutes and the minimum wait was 30 minutes.
- During the inspection, we raised concerns about escalation routes within the department especially when periods of overcrowding occurred, trauma cases arrived and during staffing shortfalls. The trust provided us with a document, which we were told was used as a guide for senior staff. This document had no development date or implementation of review. Senior staff we spoke with did not refer to this document and seemed unsure of the point of escalation.
- Senior nursing staff spoke with us about historic occasions when the department had been busy with over 100 to 123 patients in the department at one time and that it felt "unsafe". Staff spoke with us about immediate support being available in the department; however, they did not feel that wider support from the trust was always available. Staff told us about a patient having a cardiac arrest in the ambulance waiting area when the department was overcrowded, however we were unable to see an incident form to corroborate this discussion.
- During the inspection, we witnessed and staff spoke with us about in their opinion the department was "unsafe". On two occasions, 111 and 120 patients were waiting in the department. We observed a three-hour waiting time to see medical staff and patients were waiting on every corridor. On one of these occasions, we witnessed a conversation between the site manager and the nurse in charge of the department. No external support was offered, to the nurse in charge. At this point one of the major bay area's patients were awaiting two hrs 46 minutes since admission to have treatment by a nurse.
- During the inspection, due to the department being busy we observed patients waiting alone, unsupervised in main corridors, one patient was immobilised with a collar in place, and another patient had suffered a head injury and was awaiting scan results. We also witnessed on three occasions the viewing room used as a treatment area, this room was not visible from a main bay and was located on a departmental corridor, a call bell was on the wall but the patient would have difficulty accessing it. Access to suction and oxygen was not available in this area.
- We observed two formal handovers in different parts of the department. One appeared efficient and detailed, however when the new shift took over care it was apparent that key elements had not been handed over. At the time of the second handover 20 patients were in the major treatment area however, only seven were discussed with the next shift. When the inspection team questioned staff, they told us this was because staff in that area had not interacted with the other patients in the bay and they were yet to be seen. The clinical condition of 13 patients was not discussed; the longest wait for this group of patients was 2 hours 46 minutes since arrival in the bay. This handover had numerous disruptions and distractions occurring.
- On another occasion, we witnessed patients transferred into the bay areas for treatment and no formal handover

occurring, staff working in that area only recognised they had a new patient due to the computer screen highlighting a transfer. One of these patients was living with dementia and was left alone, until their family arrived.

- A modified early warning tool was in place, Sheffield early warning score (SHEWS), this tool was based on a national early warning scoring system for acutely ill patients. This scoring system supported the process for early recognition of patients who were becoming unwell. Staff we spoke with had a clear understanding of the warning scores.
- During the inspection, we observed a patient in the clinical decision unit who had deteriorated; no further monitoring had been carried out despite the patient's observations being elevated during the last recorded observations. The inspection team asked staff to take the patient observations as the patient looked unwell. The patient had a very high temperature, and required immediate treatment, the patients SHEWS score had risen, showing a deteriorating condition however, they were not transferred into the main department. Two members of staff we spoke to thought that moving a deteriorating patient from CDU into another area such as majors or resus was difficult due to the current workload.
- We observed the handover of eight patients from the main department into the clinical decision unit (CDU). The handover was brief, patient observations were not documented as carried out prior to the transfer and we were unable to find documentation of any conversations and agreement occurring prior to transfer into CDU as per the trust's protocol. Two further patients we spoke with were not aware why they had been transferred in to CDU or what they were waiting for in their treatment plan
- The CDU was also used as a quiet area to look after patients presenting with mental health conditions; staff we spoke with described this area as "been able to keep mental health patients safe". The inspection team had concerns about this area being used for this as two of the side-rooms on CDU and toilets in the unit had ligature risks present in them and were not visible from the nurse's station. During the inspection, two patients presenting with mental health conditions were on the unit. One patient had absconded; no risk assessment or missing person check had been carried out. Staff we spoke with did tell us that if patients were at risk of self-harming behaviour they were placed in a more visible area of the department. Three staff did speak with us about incidents when patients with mental health conditions harmed themselves in this area, due to being placed in a non-visible cubicle. We asked for incident reports on these cases but we did not receive them for review.
- The waiting area within CDU had a nurse call buzzer available and patients were observed through an opening in the wall. A large number of patients could be in this area, access to this area from the CDU was via a swipe card only, and not all staff working in CDU had swipe access, meaning that a patient could deteriorate in this area and not be easily accessible.
- On one occasion during the inspection, the CDU had no registered nurse present for 10 minutes, two care assistants who did not usually work in the department were left on the unit alone. The specialist (DVT) nurses were on the unit; however, they were occupied with their own patients. The inspection team raised this issue with the nurse in charge and the Matron for the department. Following concerns raised during the inspection about CDU staffing levels and care of deteriorating patients, the trust informed us that they had put a protocol in place for this area to distinguish assignment of patients, differentiate patients and manage deteriorating patients in this area. They told us that they would ensure that a substantive member of staff was always in charge of the unit.
- The inspection team were concerned about the CDU because of patient to staff ratios, the lack of adherence to admission protocols, the recognition of the deteriorating patient and the lack of dedicated medical staff for clinical review and decision-making.
- We discussed our concerns with the senior management team and were provided with interim guidelines on the use of CDU. These did not have a date of development or a date for review. The trust told us that these would be "amended" to be final guidelines. This document outlined the primary function and aims of the department. However, patients we observed in the department did not meet these guidelines and therefore may not have been cared for in the most suitable environment.
- We raised this with the trust at the time of inspection and a protocol was put in place.

- A standard operating procedure was available detailing actions to be taken if an ill child was brought into the department that required transferring to the local paediatric emergency department.

Nursing staffing

- In August 2015, the department had 111.09 WTE nursing posts within its establishment with 95.1 WTE in post and 15.1 WTE vacancies. The senior management told us during the inspection that they had no vacancies as they had recruited staff and reallocated some of the budget to the train ANPs. New funding to cover these posts had also been identified.
- We reviewed nursing staff sickness rates which were at 3.9% from April 2015 to October 2015 which was slightly above the internal target set for the emergency department of 3.75%. However, this is below the current England average nursing, midwifery and health visiting sickness rate of 5.19% for January 2015 to March 2015.
- We saw displayed for each shift the actual staffing levels for the department, the planned levels or the established levels were not displayed. We reviewed off duty and spoke to staff and noted the established staffing levels to be 12 registered nurses on an early shift and 14 registered nurses on the late and night shifts. Registered nurses were supported during the shifts with clinical support workers, clinical technicians and housekeeping staff. Staffing levels were reviewed at the start of each shift and staff were allocated to work in a specific area.
- We reviewed three weeks of duty rosters over the previous three months. We noted that out of 63 shifts reviewed, actual staffing levels fell below the established level for 49 shifts. A shortage was noted of one to three registered nurses per shift. The trust had a process to redeploy staff from other areas and request agency staff; however from records we reviewed we were unable to see whether this policy was used at these times.
- Bank and agency staff were used to fill staffing vacancies and an agency usage rate of 15.1 to 15.9% was documented in the reporting period April 2014 to March 2015. We reviewed bank and agency levels used and noted that during 7th September to 21st September 2015, 167 registered nurse agency requests were made, 99 shift vacancies were filled with 44 different agency staff used and 68 shifts remained unfilled. During the three-month period October 2015 to December 2015 we reviewed 63 shifts over a three week period and noted 44 shifts were filled by bank and agency staff, number used ranged from one to six agency/ bank staff per shift.
- When agency staff were used this was from a national nursing agency, staff spoke to us about being confident in the staff booked to work in the department from this agency. When agency staff were used they were often allocated to work in the CDU, however, they did not have access to the computer system or have key fobs to allow access and exit to the unit They also could not open the door to allow patients to enter of exit the unit.
- Prior to the inspection we received concerning information regarding the staffing levels in the department and evidence of the impact that the lower than established staffing levels was having, for example, lack of patient observations related to not highlighting patients that were deteriorating in a timely manner.
- During the inspection, we had concerns about nurse staffing levels in the resuscitation area. Planned staffing levels were three registered nurses in the area covering eight resuscitation bays. The major trauma mortality and morbidity meeting notes indicated that only one nurse was available to receive a major trauma case in July 2015. Emergency department guidelines stated two nurses as a minimum to receive trauma patients. The meeting notes stated this was to be escalated to the nurse in charge in future if staffing levels were not appropriate. During the inspection, a major trauma case required increased nursing input; this left one registered nurse caring for the other four patients in the resuscitation area. During this period a patient's monitor alarmed, this was silenced after four minutes, however no one actioned the reason for the alarm or attended to the patient for 14 minutes. Senior nursing staff we spoke with told us resuscitation staffing had been highlighted by nursing staff, as a key area for staffing improvement, due to not being able to carry out all monitoring required. The senior management team spoke with us about a recent staffing review, which had established the need for further staff in the resuscitation area.
- Within the clinical decision unit area (with 11 cubicles and 26 chairs) the planned staffing level was two qualified nurses and two health care assistants. During the inspection, we saw no extra staff allocated at times

of increased workload or break times, which in turn led to a lack of patient monitoring, on more than one occasion. In addition, agency staff often staffed this area.

- The senior management team were aware of the issues of concern regarding staffing levels, especially in the resuscitation area and "pitstop" area. Although no national formal, staffing tool was available for emergency departments, the management had recently undertaken a safer staffing review based on draft national guidance tool and a requirement for a further 19 WTE registered nurse posts had been agreed. Staff we spoke with told us that the review indicated that approximately 42 WTE registered nurses were required to meet the needs of the department, however with the emergency department pathways changing this had been re-reviewed and 19 WTE had been agreed. We were told that these extra staff would not provide any extra staff in the main department, but would for the resuscitation area, "pitstop area" and backfilling the vacancies for nurses that had undertaken ANP roles. We asked to review the staffing review paper however; this was not received.
- Three patients we spoke with highlighted that they felt there was not enough staff working in the department.
- A formal 'nurse in charge' to 'nurse in charge' handover document had been developed; this document was used and audited on a monthly basis. It recorded allocation of staff within the department, issues requiring handover, for example: bereaved relatives in the department, any patients in theatre and, missing patients. We witnessed a formal nurse in charge handover and noted this to be professional, concise discussion covering appropriate issues. It also recorded any immediate risks in the department and staffing levels. We requested the audit of this handover document to review actual staffing levels; however, we never received this to review.
- Two band seven and one band six nurses covered the trauma co-ordinator role; however, this role could not be covered seven days a week and only two out of four weekends were covered. This was highlighted as a concern in the external trauma review report.

Medical staffing

- We reviewed the medical staffing rota and talked with consultants, middle grades and junior doctors. Medical cover was available on-site 24 hours a day. Consultants in emergency medicine were available 8am to midnight on-site seven days a week. On call, consultant cover was available from midnight to 8am. This meant there were no on-site consultants in emergency medicine available between midnight and 8am despite it being a major trauma centre. This had been highlighted in the Trauma Audit and Research Network (TARN) peer review 2015.
- There were 17 WTE accident and emergency consultants employed by the trust with no vacancies. The Royal College of Emergency Medicine (RCEM) recommends there should be 10 WTE consultants between 50,000 and 80,000 patients a year. The Northern General hospital emergency department had 118,326 attendances from September 2014 to September 2015
- Medical staff we spoke with felt they required more senior medical staff to be available 24 hours a day to act as "decision makers" especially overnight. They told us that in their opinion, this would improve flow within the department.
- A higher level of junior medical staff, 35%, compared to the England average of 24% was noted during the reporting period September 2004 to September 2014. There was about the same registrar grades and consultant grade staff for this period. However, there was a lower percentage of middle grade staff; 5% compared to an England average of 13%.
- We reviewed medical staff sickness rates; it was 0.5% (April 2015 to October 2015) which was below the internal target set for the emergency department of 3.75%. This rate was also below the current England average medical and dental staff sickness rate of 1.29% January 2015 to March 2015.
- On average locum use was 9.5% ranging from 5.7% to 14.6% in the reporting period April 2014 to March 2015. There was a trust-wide medical staffing locum bank, and the management team spoke with us about the benefits of this system such as improved competence and good access to temporary staff, they had also seen decreased costs to the department of filling these roles.
- Junior doctor induction and training in the department received excellent feedback in a recent General Medical Council inspection. Junior doctors in the department we spoke with expressed the same positive comments about induction.
- Each member of the consultant medical staff had a lead role, for example, emergency planning, mental health and regular attendances.

Urgent and emergency services

- Advanced nurse practitioner roles had been developed to address the shortfall in junior doctor rotas and provide a more consistent workforce.
- A dedicated clinical lead for major trauma was available; however, this role had only been allocated one session in their job plan, this had been highlighted as a concern in the external trauma report.

Major incident awareness and training

- The trust had a major incident plan that was regularly reviewed.
- A lead consultant and senior nurse for major incidents (MAJAX) and emergency planning were identified.
- The department had a major incident and chemical, biological, radiological and nuclear (CBRN) training programme. This training included practical and theory based training. Staff had practiced working in a protective suit providing patient interventions. A practical table top exercise had been undertaken in the last year.
- Staff we spoke to had an awareness and understanding of their roles in major incidents. Should a major incident be declared the bays within the department were equipped with different signage indicating the category of patient in each bay.
- A designated area was available for decontamination. This area was due for an upgrade and detailed plans had been developed within the trust in conjunction with the department, however this work had been put on hold. The room used for decontamination was full of miscellaneous items for examples a bicycle, wheelchairs and a stool. The area was very cluttered, staff we spoke with said that they could empty the area within 10 minutes of it being required.
- Staff had received training and practical sessions on how to care for someone who may have symptoms of infectious diseases, such as Ebola; staff had undertaken practical exercises, including wearing full personal protective equipment and were aware of the pathway for the department.
- Junior doctors we spoke with were aware of the plan; they told us that they had received the major incident plan via email prior to commencing placement in the department.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We rated the emergency department at Northern General hospital as good because:

- Evidence-based pathways were in place. The clinical decision unit (CDU) within the emergency department, had pathways developed for chest pain, specialist nurse led deep vein thrombosis service and transient loss of consciousness. These pathways enabled patients to access appropriate care early in their admission process.
- There was good assessment of pain and administration of pain relief.
- An emergency department housekeeper had been introduced who ensured patients had access to nutrition and hydration.
- The introduction of advanced nurse practitioner roles helped to provide a consistent, competent workforce.
- There was participation in national and local audits, however performance was variable.

However, we also found that:

- Pathways and guidelines we reviewed had variable compliance with current National Institute for health and care Excellence (NICE) guidelines and the College of Emergency Medicine (CEM) clinical standards for emergency departments.
- The NHS England peer review visit April 2015 highlighted both concerns and positives about the major trauma service.

Evidence-based care and treatment

- Pathways and guidelines we reviewed had variable compliance to National Institute for health and care Excellence (NICE) guidelines and the College of Emergency Medicine (CEM) clinical standards for emergency departments.
- Policies, procedures and guidelines were stored on the shared electronic information system these were easily accessible by staff.
- On review of the electronic system, we noted that not all guidelines were up to date and some guidelines had no reference to current NICE guidance, for example, head injury and chest pain guidelines. Respiratory and

asthma guidelines had a review date of 2010 and referenced 2012 NICE guidance; however, new guidance was developed by NICE in 2014. A senior emergency department consultant did acknowledge that some of the guidelines required reviewing.

- The College of Emergency Medicine has a range of evidence based clinical standards. The department participated in the national CEM audits to benchmark its practice against the standards and other emergency departments, such as consultant sign off, sepsis, mental health in the emergency department and assessing cognitive impairment.
- The clinical decision unit (CDU) within the emergency department, had pathways developed for chest pain, specialist nurse led deep vein thrombosis service and transient loss of consciousness. These pathways enabled patients to access appropriate care early in their admission process.
- Local audit activity we reviewed showed that 19 locally managed audits had been undertaken in the emergency department these included reviews of trauma teams, GI bleeding and attendances.

Pain relief

- Most patients we spoke with and the notes we reviewed showed that assessment of patient's pain, and administration of pain relief had been undertaken.
- During the inspection, we witnessed on three occasions patients complaining about being in pain; in one case a patient in the department reported departmental staff had told them that they were too busy to administer. On another occasion, a relative said that they had waited 3.5 hours last time they were in the department for her relative to get pain relief and this time had waited over one hour since their first request.
- Drug cupboards had recently been introduced to the triage and the "pitstop" areas to allow rapid access to pain relief.
- In the A&E survey 2014, the trust performed "about the same" as other trust in the questions about requests for administration of pain relief and hospital staff doing everything they could to help control pain whilst in the accident and emergency department.

Nutrition and hydration

- We saw patients offered food and drink on a regular basis.
- Most patients we spoke with who were able to eat and drink told us that they had been offered food and drinks.
- Good documentation was noted in the emergency department records when patients had received food and water.
- Housekeepers and care support workers had been introduced into the emergency department to maintain nutrition and hydration. We observed the housekeeper carrying out approximately five nutrition and hydration rounds per day. Staff we spoke with told us that this round was performed overnight by a healthcare assistant.
- Vending machines were available in the main waiting area to obtain food or drinks.
- Water was available via jugs and posters were available encouraging patients that were able to obtain a drink.
- In the A&E survey 2014, the trust performed "about the same" as other trust on the question "were you able to get food or drinks when you were in the accident and emergency department".

Patient outcomes

- The department monitored their performance against a range of clinical indicators via a performance dashboard. This data included performance based on the organisational aims of delivering the best clinical outcome, employing caring and cared for staff, spending public money wisely and providing patient centred services.
- The unplanned re-attendance rate to the emergency department within seven days of discharge had been consistently lower than the England average for most of the reporting period since January 2013.
- The emergency department performed about the same as national performance, for indicators in the Royal college of Emergency Medicine standard for consultant sign off audit 2013.
- The emergency department had variable performance in the mental health in the ED audit 2014; the trust performed the same as national performance in four of the eight indicators and better than national performance for three indicators and lower performance for one indicator. It did not achieve the fundamental standard of having a dedicated assessment room for mental health patients. However, since the audit access to mental health services in the department had improved.

- The emergency department had variable performance in the assessing cognitive impairment in older people 2015 audit. The trust supplied data for three out of six indicators; they performed about the same as national performance for two indicators and worse than national performance for one indicator. The results for the fundamental standard of documentation of an early warning score was similar to other trusts.
- In the severe sepsis and septic shock audit 2014, the emergency department had variable performance with three out of the 12 indicators showing lower performance than national performance; one of these was a key indicator of antibiotic administration within the emergency department. Administration of antibiotics had only occurred on 29% occasions in the reporting period, although the percentage administered within an hour was similar to other trusts. About the same as national performance was noted in the other nine indicators.
- Following the severe sepsis and septic shock audit 2014, the emergency department carried out a review of sepsis care, to review compliance with sepsis six guidelines (a group of guidelines to manage patients with signs of sepsis). Internal audit data we reviewed showed that in September 2014, compliance with sepsis guidelines was variable. A total of 68% (target 100%) of patients were recognised as showing signs of sepsis within an hour of admission, 24% (target 100%) of patients received antibiotics within the hour and 40% of patients (target 100%) were being escalated appropriately to the senior team. Recommendations and actions were identified along with a clinical lead. In March 2015, a re-audit was carried out and compliance of patients recognised as being septic in first hour had increased to 74.5%, however numbers receiving antibiotics and being referred had improved but remained below target levels. In the conclusion of the report, it is documented that "the department was not meeting the appropriate standard in regards to sepsis recognition". New sepsis documentation and additional clinical training had been developed to aid compliance and a further review was planned.
- During the Trauma Audit and Research Network (TARN) peer review visit April 2015, it was highlighted as a serious concern that no co-ordinated major trauma service was available, including a dedicated ward to cohort trauma patients and no major trauma consultant. The review stated that this could result in not all patients receiving specialist support; these issues had been highlighted previously in a 2014 report. The trust had undertaken an audit to ascertain the timing and nature of major trauma patients not seen by an emergency department consultant within 5 minutes. This audit demonstrated that only small numbers were not seen and those did not require emergency department consultant input.
- Major trauma patients were discussed on a daily basis at the major trauma meeting. Patients with multiple trauma injuries involving neurosurgery were treated at NGH. Neurosurgical trauma only injuries were transferred, once stable, directly to the Royal Hallamshire Hospital.
- Major trauma outcomes were measured via a major trauma dashboard. The trust scored higher (65%) than the England average (39.6%) on meeting guidelines for open fractures and for administering medication within three hours of patients receiving blood products (100%) compared to the England average (82.4%). The department scored slightly lower (85.7%) than the England average (88.8%) on meeting NICE head injury guidelines for patients receiving a scan within 60 minutes of arrival in the reporting period quarter one, 2015.
- The department told us regular audits on fractured neck of femur and percutaneous coronary interventions were undertaken. Fractured neck of femur data showed that in 2014, 63.7% of patients with attendance to the emergency department with a fractured neck of femur were admitted to orthopaedic care within 4 hours. This was better than England average performance of 48.3%
- A new dedicated stroke pathway had been developed with direct referrals taken from the emergency department consultant, or direct admission to stroke unit.

Competent staff

- The trust had an internal appraisal target to achieve of 95%. Appraisal records we reviewed showed that the department was below the target with 80% of nursing staff and 75% of medical staff as having appraisals.
- The department had a clinical educator, this person had worked within the emergency department prior to the clinical educator role.
- New nursing staff to the department had a competency based training period. During this period staff had to complete a competency booklet. They were not allowed

to work nights or long days; this allowed them to be supervised. Newly qualified staff also received supernumerary status for eight weeks and were allocated two mentors to work alongside. However, five newly qualified staff we spoke with told us that because of the restrictions they had not been able to work many shifts with their mentors. During this period and until declared competent new staff were not allowed to work in the resuscitation area and triage area.

- Advanced nurse practitioner (ANP) roles had been developed. Registered nurses received further training to provide alternatives and to compliment acute the medical staffing, these staff had increased competencies to allow them to assess and treat patients. They were available 08.00am to midnight, seven days a week. Four ANPs had qualified and four ANPs were still in training. The department saw this as having many benefits for example improving nurse retention due to improved career choices for nursing staff. Increased financial benefit as reducing the spend on junior medical locum staff and increasing a consistent, competent workforce.
- Emergency nurse practitioners (ENP) were also available to provide assessment and treatment to patients within the minor injuries department, These staff had received extra training and increased competencies to allow them to carryout treatment.
- Trauma nurse courses training rates we reviewed showed that 30.6% of nursing staff (33/108 staff) had been on this training course. It is recommended for a trauma centre emergency department to have a minimum of 25% of nurses trained. The department undertook weekly trauma simulation exercises and training events; these were run by the trauma team staff.
- The department had recently introduced clinical technicians, staff who assisted the department by carrying out tasks such as ECGs, cannulation and catheterisation. Their training was via a competence-based programme. They also had a buddy to work alongside in the first few months.
- Staff we spoke with told us the trust were developing specific sessions on the revalidation of registered nurses. All nursing staff we spoke with were aware of the need for revalidation.
- Training on mental health needs had been highlighted as requiring improvement; a session had been arranged specifically for junior medical staff. However, newly qualified nurses highlighted to us their concerns over knowledge of dealing with patients with mental health needs. The liaison team had previously run bespoke departmental training sessions, but had been unable to run these recently.
- Specific professional updates were delivered in the department, these included training on dementia, mental capacity and the emergency department, revalidation and student supervision updates.

Multidisciplinary working

- Care was delivered using a number of different pathways between the emergency department and admissions areas. Teams within the trust had recently worked together to develop a new model of emergency admissions.
- Staff we spoke with talked positively about the clinical lead and clinical director roles in the emergency department and other areas of the organisation. However, three senior nursing staff we spoke with said there needed to be a greater level of cohesion between some senior medical staff in the emergency department and senior nursing staff, for example they said that they did not always feel supported in decision making.
- Clinical nurse specialists came to the department to provide clinical expertise and review patients if needed.
- A front door response team were available in the department to prevent admissions and facilitate early patient discharges.
- The mental health liaison team was located within the department providing timely assessment to patients with mental health needs between 7 am and midnight seven days a week. Out of hours, the department referred patients to the crisis team.
- The emergency department consultant mental health lead, spoke with us about improvements in communication with the local trust providing mental health services. The lead spoke positively about the impact this joint working was having on the department, for example improved communication and improved access to mental health services within the department.
- Staff had access to the alcohol/substance misuse specialist team and spoke with us about a positive working relationship with this team.
- MDT working with other departments of the hospital was described as good during the inspection.

Urgent and emergency services

- Transfers between sites were undertaken where clinical need required, for example neurosurgical specialities were based at the Royal Hallamshire hospital.
- We witnessed positive communication between medical staff and nursing staff from other areas of the hospital, such as the stroke specialist team.
- Staff from the emergency department attended a patient flow meeting three times a day; this was an organisational meeting with colleagues from other areas of the hospital.
- Community multi-disciplinary teams (nursing, support workers, physiotherapists, and occupational therapists) were available within the department to facilitate discharges and avoid admissions.

Seven-day services

- Access to radiology services was provided within the department 24 hours a day, seven days a week, to support clinical decision-making.
- Access to diagnostic services was available 24 hours a day, seven days a week to support clinical decision-making.
- Consultant cover was available on-site 16 hours per day with on-call cover outside of these hours. Middle grade cover was available 24 hours a day.

Access to information

- A national computer patient administration programme had recently been introduced; staff we spoke to told us about issues with the introduction of the system for example, triage taking longer and performance data not being accurate.
- An electronic pathology system was also in place. Staff could access IT equipment throughout the department.
- The electronic computer system alerted staff to any issues of concern about the patient that had been previously identified.
- Discharge letters were prepared for GPs via the national computerised administration system. Staff told us discharge communication had improved since the introduction of the system.
- Staff we spoke with told us about issues with agency staff not being able to input information onto the computer system due to not having a password; this placed extra pressure on substantive staff as they had to input data for agency staff. During the inspection, we witnessed a regular agency staff member trying to obtain passwords to the computer system which they were unable to access.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with, understood the principles of consent including the Gillick competency guidelines, which relate to the obtaining consent from children and young people.
- Nursing and medical staff obtained consent via both verbal and non-verbal routes. The staff we spoke to were aware of how to gain both written and verbal consent from patients. We observed clinical staff obtaining consent from patients, before undertaking clinical procedures.
- Where patients lacked capacity to make their own decisions, staff we spoke with understood application of the Mental Capacity Act and best interest decision-making process.
- Staff we spoke with were knowledgeable about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

Are urgent and emergency services caring?

Requires improvement

We caring as requires improvement because:

- When the department was busy and overcrowded we found patients did not always have a positive patient experience whilst in the department. There were times when patients did not feel well supported and cared for, and times when patients told us they did not have enough information on the next step in their attendance.
- Staff had difficulties in protecting and maintaining patient's privacy and dignity and confidentiality, due to the department being overcrowded. Patients were often situated directly next to another patient, with no separation or adjacent to another patients curtains or in an inappropriate area such as a hospital corridor.

However, we also found that:

- Staff working in the emergency department appeared genuinely caring and highly motivated. They were aware of the impact that an overcrowded department and poor patient flow had on patient experience.
- Patient centred care plans were available for frequent attenders into the department.

Compassionate care

- The NHS Friends and Family test (FFT) is a satisfaction survey that measures patient's satisfaction about the care they received. There was a 42.7% response rate between April 2014 and April 2015.
- In June 2015 85.1% of patients would recommend the service, this was slightly below the England average rate of 87% June 2015.
- We spoke to 26 patients, in every area of the emergency department. Twelve patients provided positive comments and experiences such as staff being kind, professional, caring. Ten patients provided negative comments and experiences such as poor experience in waiting room, and poor communication. Two of these patients described their experience as "horrendous". Four comments received were neutral.
- During the inspection staff appeared to be extremely busy, however when we observed interaction with patients it was positive.
- We observed a member of the nursing team provide excellent reassurance and support to an abusive patient. The patient was making threats of violence to the member of staff and the staff member dealt with the patient in a calm and controlled person centred manner.
- On review of the moments of excellence nominations, we saw evidence of good patient care, for examples staff nominated personally by colleagues for being calm and respectful to patients whilst in the resuscitation room. Another staff member was nominated for the care of a patient with mental health issues and good safeguarding referrals.
- On two occasions, we heard patients awaiting ambulance handover in the ambulance lobby area complain about being cold. Patients in this area were often in touching distance of other patients both male and female, no screens were used to separate patients. On another occasion, a patient waiting on a corridor was cold and trying to cover himself with his coat. The inspection team asked staff to provide a blanket.
- During the inspection, we saw patients waiting in corridors and in the middle of bays; these patients did not have access to call bells. On one occasion six out of ten patients did not have access to their call bell. Staff we spoke with were upset at patients being nursed in the corridors and felt that this practice was unacceptable. They highlighted to us concerns about maintaining privacy and dignity, confidentiality and difficulties delivering basic care needs. During the inspection, in one three hour period we saw between eight and 13 patients nursed in the middle of bays and on corridors. We also observed chairs, sharps bins and wet floor signs in the middle of bays, making the area very cluttered and difficult to respond to an emergency or walk safely.
- Staff tried to treat patients with privacy and dignity. Curtains/doors were closed when discussing issues with patients, however due to the number of patients in the department and flow within the department, this was difficult to maintain. Patients were often seeing sitting or lying on a trolley directly next to the closed curtains of another patient. One patient we witnessed having a blood test taken in the middle of a busy bay and another patient having observations taken in a waiting area. Three patients highlighted to us concerns over privacy and dignity due to waiting in corridors.
- Confidentiality was not always maintained within the resuscitation area as we found the name and details of previous patients that had occupied cubicles written on the whiteboard, some of these cubicles were empty however, some cubicles had new patients occupying them.
- In the A&E survey 2014, the trust performed about the same as other trusts for the question "Did you feel threatened by other patients or visitors?"

Understanding and involvement of patients and those close to them

- In the A&E survey 2014, the trust performed about the same as other departments in 23 out of the 24 questions. In the question "did you have enough time to discuss your health or medical problems with the doctor or nurse? The department performed better than other trusts.
- Five patients we spoke with said that they had been involved in their care decisions and were aware of the treatment plan risk and benefits of treatment had been discussed with them. Three patients we spoke with told

us that they did not feel that they had enough time to ask questions, were not aware of the ongoing treatment plan and had did not feel that enough appropriate information had been provided.
- Patients we spoke with were not always aware of their discharge arrangements and actions required prior to discharge occurring.
- Within the clinical decisions unit we observed patients waiting in the seated area asking staff on numerous occasions questions about test results, waiting times and plans.

Emotional support

- We observed an advanced nurse practitioner undertake an assessment of a patient. The patient had been very distressed on first contact however; the nurse provided support, reassurance and calmed the patient. Once this had occurred we witnessed a positive knowledgeable assessment.
- Clinical nurse specialists, such as nurses specialising in stroke care and treatment, were available in the department to provide specialist advice to patients and staff.
- A pilot project of emergency department pastors was in place in the department one afternoon a week providing support to patients and staff.

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Requires improvement

We rated the emergency department at Northern General hospital as requires improvement for responsiveness because:

- We could not judge responsive times as the department was unable to provide any data, or confirm accuracy of data to report on performance activity in the emergency department following the introduction of a new computer system on the 28 September 2015.
- The department only met the standard to admit, transfer or discharge 95% patients within four hours of arrival on average 90.3% of the time from September 2014 to September 2015.
- During the inspection, two patients waited in the department for over 16 hours from attendance.

However, we also found that:

- Services had been reviewed and new pathways developed to improve the access and flow within the department. The recommendations from the review had only recently been implemented so the full impact of the changes had not yet been achieved.
- It was easy for people to complain or raise a concern and patients who did complain appeared to be treated with compassion. Complaints and concerns were always taken seriously and departmental responses to complaints were timely. There was evidence of robust investigation and of learning from complaints and concerns.

Service planning and delivery to meet the needs of local people

- A year on year increase in attendances had been seen from approximately 9,565 attendances a month from April 2013 to March 2014 compared with 9,974 attendances a month between April 2014 and August 2015. Daily attendances had risen from average by 307 to 324.
- A review of the emergency department pathways into the trust had been undertaken. It was anticipated that attendances would decrease because of this work. Recommendations from this work had been or were in the process of implementation, for example, the stroke referral pathways.
- The trust told us that the department worked in close collaboration with the GP collaborative service located on site. However, emergency department consultants told us that because of patient safety concerns due to the service being located a distance from and outside of the main department, they very rarely diverted people from the emergency department to the collaborative.
- An initial rapid assessment and categorisation of emergency ambulance arrivals area had recently been re-introduced the "pitstop" to improve patient care and flow through the department. An emergency department consultant led this area.
- Recent improvements had been made in the access to mental health provision, for example-improved access to on site mental health specialists from 8am to 12md.
- As part of the review recommendations, GP referral pathways were changed late November 2015. Patients

referred from a GP were now admitted directly to a ward assessment area, however during the inspection we witnessed patients arriving in the department from GPs for assessment.

Meeting people's individual needs

- The department was accessible for people with limited mobility and people who used a wheelchair. Wheelchairs were available within the department if required and disabled toilets were available.
- The reception area had a dedicated hearing loop system; staff working in this area told us where people were identified as having hearing loss they spoke slower and more clearly.
- The reception area staff we spoke with said that when patients arrived whose first language was not English they relied on the patient bringing an English-speaking representative with them, this was not in line with trust policy.
- Nursing staff were aware of how to access translation if required.
- No leaflets promoting health awareness or other treatment choices were available in the main waiting area. Posters were available in the CDU waiting area on domestic abuse, deprivation of liberty safeguards, pharmacy information and specific conditions advice. Information was available in the main reception area showing waiting times, apologies for the wait and alternative services available. This information was not shared with the public in the waiting room.
- A seven day, 7am to midnight mental health liaison team provided expertise in the department for referrals to patients with mental health conditions. The lead consultant for mental health in the emergency department had regular meetings with the trust who provided mental health services to promote joint working.
- Two rooms were available for use for relatives of recently bereaved patients or critically ill patients. One of these rooms linked to a private viewing room, where relatives could spend quiet time with their friend or family member.
- Individual care plans were developed and were available for patients with regular attendances at the department.
- As the children's and the adult emergency departments were provided by separate trusts, the department and young people services had recognised the challenges this could bring to children and young people moving from one service to another. The department had undertaken work to improve the transition process for children and young people moving to adult services, an open invite was available to patients from a local children's centre for patients with specialist needs who were likely to require emergency services to visit the emergency department during the transition phase.
- A memory box had been developed within the CDU. This box contained papers, activities and photographs to be used with patients living with dementia. A yellow patient wristband was used to highlight patients living with dementia to help staff provide appropriate care.
- An alert was available on the computer based administration system for patients if they were diagnosed as living with dementia or learning disabilities.
- Friends and family leaflets were available in the main department in different languages.

Access and flow

- Due to the implementation of a national computer patient administration programme the department was unable to provide any data, or confirm accuracy of data to report on performance activity in the emergency department following the introduction of the system on the 28 September 2015. Data used in this report is prior to the implementation of the new system or data the trust provided on paper and examples observed by the inspection team during the inspection.

- The Department of Health standard for emergency departments is to admit, transfer or discharge 95% patients within four hours of arrival. Trust-wide performance data we reviewed from the reporting period August 2014 to July 2015, showed over 95% of patients were seen and treated within 4 hours. On two occasions, the percentage dropped to 80% in December and January 2015; since this period the percentage had increased to above the 95% standard. This data included attendance data for the local minor injuries unit and urgent care eye clinic. It is important to acknowledge that an emergency department not seeing many paediatric attendances is more difficult to maintain performance than an emergency department with routine paediatric attendances due to shorter attendance times and decreased admissions from children.

Urgent and emergency services

- When this data was examined for this site only, it showed that in the reporting period September 2014 to September 2015 the hospital was only meeting this standard on average of 90.3% occasions. Data ranged from 74.8% December 2014 to 97.5% August 2015. The department only met the standard 7 weeks out of the 51 weeks within the reporting period. However, the national standard for all types of emergency departments was met by the trust for 19 out of 51 weeks.
- The percentage of emergency patients waiting between four and 12 hours from the decision to admit to admission had been in line with the England average from April 2014 to July 2015. However, the emergency department review identified that on average between January 2012 and January 2015 167 patients breached the four-hour target and 30 patients waited between four and 12 hours every week. It also identified that a periods of peak pressure over winter 500 patients breached the four hour wait and 160 waited between four and 12 hours.
- Data supplied by the trust following the inspection showed that 740 patients breached the four hours standard in August 2015. The total monthly attendance during the reporting period was 10,173 patients so this equates to on average 7% of all attendances. In the same reporting period, the maximum daily breach rate was 83 patients and the minimum was one patient.
- During the inspection, we reviewed patient's records and from 58 admissions records 23 patients had breached the four-hour standard, 13 patients did not breach and for 21 patients it was unclear from records whether a breach had occurred.
- The national average for the percentage of patients leaving the department before being seen (recognised by the Department of Health as an indicator that patients are dissatisfied with the length of time they have to wait) has been higher 3.1% in April 2015 than the England average 2.6%. At some points, this had been almost double the England average at 4.1% October 2014 and consistently above the England average for the 12 months April 2014 to April 2015.
- Total time in the emergency department had been below the England average at 130 minutes between January 2013 and July 2014; however, it had increased to on average 165 minutes in December 2014 and was above the England average . When compared to the same reporting period in December 2013, this is an increase of 35%. This reporting period was recognised nationally as being challenging for many emergency departments. Records we reviewed during the inspection showed that on average patients waited in the department on average for over five hours.
- We reviewed trust wide A&E attendances data which resulted in an admission to hospital, this was 19.1% of all attendances from April 2015 to June 2015. This was better than the England average of 21.7%
- The trust and NHS England had recently commissioned a review of the emergency department, as they were aware of issues leading to poor performance in the department. The aim of this review was to improve and sustain acceptable performance levels. This report highlighted 14 recommendations, a further two recommendations had been added by the trust due to further concerns.
- It was highlighted within this report that the emergency admissions rate rather than the emergency department attendance rate was the key factor in ED 4 hour performance, which lead to the backlog of admissions in the emergency department, the deficits in emergency department capacity and overcrowding issues. All of which potentially have an impact on patient experience and increase clinical risks.
- Staff we spoke with talked to us about the pathways changing and the positive impact this was having on attendances in the department. However, they also spoke to us about the impact to emergency patients who were waiting for a bed to become available for admission. They felt that patients were now waiting longer in the emergency department, due to non-emergency department patients being a priority; we were unable to corroborate this discussion due to recent implementation of the pathways and data not been available.
- The department had access to a clinical decision unit (CDU). This unit was adjacent to the main department and had 11 cubicles and a waiting area with 26 seats. Staff told us it was used to nurse patients that had an agreed treatment plan. During the inspection, we noticed patients that were in the unit without awareness of the reason for CDU admission, without agreed treatment plans and/or were awaiting blood test results. On occasions, patients told us that they were awaiting blood test results, however it became apparent that the correct tests had not been requested during their attendance in the main department, meaning the

patients had to re-tested and wait for further results. We also noted a lack of clinical decision-making in the CDU as no senior medical staff were permanently based in the clinical decision unit.

- Concerns had been raised in the emergency department review that the CDU was being used partly inappropriately as an admissions area to reduce stress within the emergency department. The report also highlighted some concerns about the use of the CDU in relation to performance times and confusion from staff about the role, function and time recording of patients within CDU. The senior management team had met with the chief operating officer (COO) to clarify the issue and staff were now confident that the four-hour clock would stop, however the decision to admit clock would continue.
- We reviewed data, which showed that on average 75 patients attended the CDU in a 24-hour period in November 2015, with a maximum of 98 patients and a minimum of 63 patients per 24 hours). During the inspection, we noted that out of 31 patients reviewed in CDU 17 patients had been in the emergency department for over 4 hours with two patients over 16 hours. However the decision to admit target of 12 hours was not been breached due to the decision being made late into the attendance. Two members of nursing staff spoke with us about concerns over the length of time elderly patient remained on CDU. Three members of staff highlighted to us frustrations about not being able to obtain beds for patients who wait in the unit for long periods.
- The trust provided us with interim guidelines on the use of CDU during the inspection; these did not have a date of development or a date for review. The trust told us that these would be amended to be final guidelines. This document outlined the primary function and aims of the department. This document also made clear that the "four hour time in the emergency standard" would stop due to admission into CDU, however the "12 hour trolley wait clock" would continue.

Learning from complaints and concerns

- The emergency department had a process that addressed both formal and informal complaints that were raised via the Patient Advocacy and Liaison Service (PALS). When complaints were received, these were acknowledged with early intervention, telephone calls and meetings were offered to discuss face-to-face issues. A formal response was developed and shared with the complainant.
- Staff could describe their roles in relation to complaints management and the need to accurately document, provide evidence, take action, investigate or meet with patients or relatives as required. Senior staff we spoke with were aware of the number of complaints and the themes received for their area.
- The governance report detailed clearly the number of complaints within the quarter received, the number closed and the category of risk. There were 30 new complaints made in quarter two 2015. In this quarter 23 had been unfounded complaints and 12 had been upheld. The directorate summary for emergency medicine dashboard highlighted the target for the number of complaints answered within 25 working days to be 85%; the directorate had only met this on 48% of occasions.
- Analysis showed that the top three complaints were associated with lack of care, medical (14/30), lack of care, nursing (10/30) and communication and information (4/10). The senior management team were aware of the current top three risks.
- A dedicated nursing governance lead investigated and managed complaints within the emergency department. Following a complaint being received staff members named in the complaint or on duty at the time of the complaint, received a letter asking them to reflect on the issues and provide immediate thoughts. This response was used to aid the response to the patient.
- A recent development was that complaints and responses were being shared anonymously with staff via a folder in the restroom; this was to share learning and improve patient experiences.

Are urgent and emergency services well-led?

Requires improvement

We rated well led as requires improvement because:

- The arrangements for governance did not always operate effectively. The departmental risk register did not include some of the issues found on inspection

including the use of CDU, escalation of deteriorating patients or the TARN peer review outcome and it did not show when the risks were last reviewed, or any actions taken to minimise the risk.
- Although the senior management team were knowledgeable of issues and had taken a number of actions to improve the patient experience and flow within the department, these had not yet had an impact on patient experience.

However, we also found:

- A clear vision and strategy for the future of the service had been developed.
- Staff working within the department were motivated and spoke highly of the positive culture.
- There was a clear proactive approach to improving models of care to improve patient experience.

Vision and strategy for this service

- A directorate five year strategy dated February 2013 was available and the senior management team were aware of this strategy. Strengths and weaknesses were documented and developments were noted such as the implementation of the IT system.
- During the inspection, the senior management spoke with us about the current accident and emergency department business plan. This document was a first draft of the plan for 2016/2017 it had not yet been approved by the trust. It included priorities, actions and risks however; it did not include any deadlines for actions taken.
- The trust and NHS England had recently commissioned a review of the emergency department, funded by NHSE and Monitor, as the trust were aware of issues leading to poor performance in the department. The aim of this review was to improve and sustain acceptable performance levels. This report highlighted 14 recommendations, a further two recommendations had been added by the trust due to further concerns. The trust executive group had discussed and agreed the recommendations at the September and October 2015 board meetings. Examples of the recommendations were specific to the emergency department such as referral rights to all specialities from consultants in ED, a revised model for assessment of geriatric and stroke patients referred to the emergency department, emergency department pathways triggers for escalation and action cards to be implemented and restriction of the emergency department to be for unscheduled care only. Other recommendations were for the trust to implement in other directorates; such as cultural change in directorates other than ED to take greater ownership for their patients, identification of areas for assessment of patients within directorates and improved bed management. The senior management team told us that although these recommendations had been agreed some actions still required implementation. Other actions such as moving to assessment areas within directorates had been implemented quickly. The senior management team were positive about the recent work undertaken by the trust on emergency department pathways and the impact this was having on the department. They were also aware that further work streams were required including with primary care services to encourage the public to keep the accident and emergency department for emergencies only.
- The senior management team were aware of the challenges within the department such as flow, patients leaving before being seen, the impact on good patient experience and performance targets. Senior leaders within the department had been instrumental in the workforce review and changing admission pathways within the department.
- All staff we spoke with in the emergency department were aware of the vision for the emergency department service, they had developed a “strapline” for the department “High quality care for all patients at all times”.
- The trust had developed a set of values; staff referred to these as PROUD values. PROUD stood for Patient first, respectful, ownership, unity and deliver. A set of core behaviours underpinning these values had been developed for use in appraisals. Staff we spoke with were aware of the PROUD values of the trust and were aware of the individual vision for the service.
- Recruitment and selection of staff within the emergency department was based on the core values of caring staff, alongside the PROUD values of the trust.
- The trust saw the urgent care pathways as one of their challenges due to the care of people in inappropriate settings, emergency pressures, issues with social care and mental health requirements.

Governance, risk management and quality measurement

- We reviewed a departmental risk register. This document identified six risks, but it did not show when the risks were reviewed or any actions taken to minimise the risk. It reflected some current risks relevant to the operational effectiveness of the department. However, it did not include some of the issues found on inspection including the use of CDU, escalation of deteriorating patients or the TARN peer review outcome.
- The quarter two 2015, governance report stated that the department had eight risks identified, one graded as extreme, four high risks, three moderate risks. One risk was past its review date, all eight risks had risk assessments. We requested a complete risk register however; we never received another document to review.
- The senior management team spoke with us about their top three risks being overcrowding, staffing and ambulance-waiting times, these were on the list of risks we received. They spoke to us and shared with us actions that they had taken in relation to the flow within the department, for example discussions and emails to the senior management team and the changes in pathways. They were aware that an overcrowded department leads to poor patient experience and poor staff morale. These were all risks we witnessed during the inspection.
- A governance system was in place with regular monthly governance meetings within the department and within the directorate. We reviewed two sets of governance minutes and noted a well-attended meeting; items discussed included incidents, complaints and patient outcomes.
- Performance data was reported, using a performance dashboard and performance within the department was discussed at the monthly directorate meetings.
- A dedicated nursing clinical governance lead with responsibility for incidents, complaints investigation and governance within the department had recently been strengthened, to include a further part time post. This team had good systems in place to improve investigations, learning and sharing issues of governance in the department.
- Staff we spoke to were clear and consistent about the challenges the department faced and they were committed to improving the patients' journey and experience.

Leadership of service

- The emergency department had a clear management structure. The department was part of the emergency care group led by a clinical director, who was supported by clinical leads in each area of the directorate for example mental health lead, trauma lead and acute physician lead.
- The senior nursing staff had clear roles and responsibilities and lead on various aspects of the department for example, staff roster, major incidents and IT developments.
- The senior nursing team were rostered to be available on site seven days a week. The senior nurses each led a team of nursing staff in the department carrying out appraisal, supervision and support for staff.
- The senior management team held monthly departmental meetings; the matron and emergency department nurse managers attended monthly consultants meetings. Attendance was good at the emergency directorate meetings and included discussion about incidents, finance and departmental performance data.
- From our discussions with staff, the leadership team were cohesive and strong, staff felt they were listened too when they raised issues of concern and there was confidence and respect in the management team.
- The senior management and nursing staff spoke to us about an increased reporting of stress within departmental staff over the past year; the department had undertaken a stress survey with all staff to understand the reasons for this increase. They had undertaken work to highlight to people the effects of stress, behaviours attributed to feeling stressed and how these behaviours affected others both patients and relatives. One of the fortnightly focus themes had been "not on stage" this focus was about improving relationships and professionalism in the department.
- The department had developed a six-month coaching programme for senior nurses providing coping mechanisms and support.
- Senior nursing staff had recently received comments back from nursing staff within the department on their leadership styles and personality traits; senior nursing staff felt this helped them understand their styles of leadership.

Culture within the service

- We found a culture in the emergency department of being open and transparent. Good practice and learning

from mistakes was encouraged, staff we spoke to felt able to raise concerns and these concerns be listened too. Staff we spoke with described the culture as positive, and challenging due to the pressures of the department.

- Staff morale within the emergency department was good. Staff acknowledged and shared with us that at times over the last year morale had been low, due to the workload within the department. Staff we spoke with were passionate about working in an emergency department.
- Staff spoke about their colleagues in a positive manner. The senior management team described the emergency department team as positive, resilient, committed and up for a challenge. Domestic services staff said they felt included as part of the department team.
- The senior management team described themselves as visible and engaging, they acknowledged that some decisions did not always make them popular; however, they felt they were responsive to the clinical team and the needs of the department. This was a view shared by many staff in the department.
- Five newly qualified nurses we spoke with talked to us about their enthusiasm and their reasons for working in the department and everyone being supportive and about the positive team spirit.
- A formal nursing debrief was held for the whole team at the end of every shift led by the nurse in charge of the department, staff were able to raise concerns about the shift and give thanks to individuals for work undertaken during the shift.
- The number of thank you cards and letters formed part of the quarterly governance report, 16 were received in quarter two 2015.
- The biggest worry of both medical and nursing staff we spoke with was the overcrowding in the department and the staffing levels.

Public engagement

- The department took place in the accident and emergency survey of patients.
- A public charity initiative financed the development of the helipad; this initiative included a charity bike ride undertaken by both staff and the public.
- The department had developed a patient's leaflet, which set out the patient's journey within the emergency department; we reviewed a draft of this document and noted it to be a well-developed useful leaflet.
- The department regularly meet with patients who complained or were complimentary about the service.
- The department had developed a role on the governance committee for a patient representative, this role was due to commence in the near future.

Staff engagement

- Department managers spoke with us about an "open door policy" for staff to discuss issues with them. During the inspection we noted a notice on the managers door stating an appointment was required, we discussed this with senior staff and they spoke to us about having to take this action due to interruptions whilst speaking to staff, they did tell us that they were still available to staff.
- Regular sharing of information sessions had been developed; these were called fortnightly focus. These sessions were delivered from a set script, delivered by the nurse in charge of the shift in the handover period daily for a two-week period which ensured that most staff heard the information. Examples of themes of these sessions included sepsis, pain management, safeguarding and the not on stage initiative.
- During the department debrief sessions moments of excellence were discussed; this was the opportunity for any of the emergency department team to commend colleagues internally or externally of the good work during that shift and for the trust's "Moments of excellence" nominations. Staff we spoke with and email evidence we saw showed us that staff were very proud of the nominations. The whole team were commended on 13 occasions in one month.
- We observed a debrief session following a trauma case and witnessed all staff having an opportunity to discuss issues and concerns. All staff had an opportunity to respond whether any improvements could have been made. Domestic service staff also told us they were involved in debriefs if had witnessed traumatic cases.
- Staff forums had been developed for emergency department sisters, staff nurses and support workers to provide peer support and time for discussions. Minutes from the forums were available on the shared computer system.

- When a thank you card or message was received, staff were informed and a note was placed on their personal file.
- The "pitstop" area in the main department was an idea from a member of staff as a way to improve flow within the department.
- Staff consultation had developed the "strapline" for the department.
- Data from the directorate emergency medicine performance dashboard year to date 2014/2015 indicated that 56% staff would recommend the trust as a place of work, this had decreased from 68% in both 2012/2013 and 2013/2014.
- Staff had developed a "you said we did" board for staff engagement. Examples of this were staff required more opportunity for leave during the summer months; the senior management team had cancelled all training in August to facilitate this request. Staff also requested to be made more aware of outcomes from meetings; the senior management team had developed an area on the shared information drive to store this information for all staff to access.
- A shared computer system was available to all staff this system gave all staff access to meeting minutes and other information to keep them informed and involved.

Innovation, improvement and sustainability

- The team had recently received a "highly commended award" for its work on the "pathway for vulnerable young people" in partnership with another provider. This work was to identify young people in the 16-18 group who were admitted to hospital following high-risk behaviour, a referral was made with their consent onto a pathway to gain further help for the young person.
- Advanced nurse practitioner roles provided emergency department stability, career progression, improved leadership and succession planning.
- Emergency department pastors had been developed as part of a pilot project and staff talked with us about improved levels of support to patients and staff.
- The development of handovers, debriefs, checklists and fortnightly focus themes, improved communication and learning within the department.

Medical care (including older people's care)

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

Information about the service

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

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

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

Specialties based at NGH include - acute medicine, respiratory medicine, cardiology, diabetes and endocrinology, gastroenterology and renal services. The geriatric and stroke medicine directorate is mainly on the NGH site, although there are strong links with the neurology hyper-acute stroke service and the stroke unit based at the Royal Hallamshire Hospital.

Between January and December 2014 there were 116,430 medical admissions to Sheffield Hospitals Foundation Trust (SHFT), 49,100 of these were at NGH. Medical admissions to NGH were 60% emergency cases, 5% elective admissions and 35% day cases. The three specialities with the highest admission rates were gastroenterology (including endoscopy) 22%, general medicine 15% and cardiology 14%. There were approximately 663 inpatient medical beds at NGH.

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

We visited a number of medical wards including; Hadfield 1, 2, 3, 4 and 5, Huntsman 5, Chesterman 1 and 2, Brearley 4 and 7, Renal E and F, the acute medical unit (AMU) and medical assessment centre (MAC), the frailty unit, the coronary care unit (CCU), the cardiac catheter lab and discharge lounge.

We spoke with 35 patients and carers, and more than 60 staff. We attended a number of focus groups and we observed staff deliver care on the wards. We looked at 17 care records and 29 medicine prescription / administration cards and reviewed the trust's performance data.

Medical care (including older people's care)

Summary of findings

Overall, we rated this service as good.

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

There was no evidence of increased risk of mortality in any of the medical specialities. There was good evidence of effective multi-disciplinary team working and good provision of seven-day services. Patients pain relief and nutritional needs were met. There was good evidence of learning from audits and the improvements being made. Staff received training relevant to their role to develop expertise and competence was assessed and documented. Staff had a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards. However, appraisal rates for both nursing and medical staff were below the trust's targets.

We observed staff in all areas treating patients with kindness and respect. Privacy and dignity was maintained at all times and we saw staff answering patients' questions patiently and cheerfully with a caring manner. Patients were very happy with their care from all professional groups and told us staff had gone out of their way to ensure their comfort and dignity. Patients told us they were involved in decision-making and felt listened to.

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

However, high numbers of patients were boarded (moved to a ward) outside of their speciality ward and 20% patients were moved twice or more during their hospital stay.

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

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

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

Medical care (including older people's care)

Are medical care services safe?

Good

We rated the safety of the medical service as good because;

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

However, we also found:

- There were areas of poor practice relating to medicines management and mixed practice regarding infection control procedures.
- There were some areas where staffing fell below planned levels on a regular basis, although the trust was mitigating risks as far as possible.
- Compliance with mandatory training was below trust targets in some areas and across disciplines.
- Nursing care guidelines (care plans) were not easily accessible to all nursing staff providing care.

Incidents

- There were no never events in this service between August 2014 and July 2015 (Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers).
- During the same period, there were nine serious incidents for the medical service trust-wide. Two of these incidents were unexpected deaths; two were medication incidents, one diagnostic incident, one slip/ trip/ fall, one communication issue and two others.
- Medical services at NGH reported 2091 incidents in the six months March to August 2015. Of these, two were catastrophic (unexpected deaths), 12 resulted in major harm, 29 resulted in moderate harm and the remaining 2048 were low or no harm incidents. The major categories of incidents graded as moderate harm or above were; slips, trips, falls; pressure ulcers and drug related incidents.
- Falls incidents were investigated by senior nursing staff and were presented to a falls meeting to look at the root causes and identify areas for learning and action for all wards and staff. Actions taken because of learning from falls included a relaunch of a falls booklet, awareness raising regarding manual handling and the introduction of a handover sheet to ensure patients at risk were identified to all staff. Documentation following discussion with relatives had also been improved.
- Staff on the renal unit told us that doors were to be removed on some of the bays to improve visibility of patients to help reduce the number of falls.
- Staff were aware of how to report incidents using the electronic incident reporting system and how to escalate incidents to their line manager.
- We saw that near misses were also reported in the cardiology wards and the coronary care unit (CCU).
- Incidents reported on the electronic reporting system went automatically to the ward manager for attention and investigation.
- Staff felt they were encouraged to report incidents and be open and honest with patients if they made a mistake or a patient suffered harm.
- All staff had received written information regarding duty of candour and were able to tell us what this meant. Staff had been able to access awareness sessions regarding duty of candour and managers involved in responding to patients had attended additional training.
- Staff on one ward were able to tell us how the duty of candour had been met in relation to a patient who had suffered a fracture because of a fall. The patient's family had been written to and were invited to a meeting to discuss the incident and the outcome of the investigation.
- Staff told us how e-learning regarding the safer use of insulin had been added to mandatory training because of previous incidents.
- Staff in AMU told us that the lessons learnt from the investigation of serious incidents were disseminated via email circulation of the clinical governance meeting minutes.
- We saw that serious incidents were investigated using root cause analysis methodology and the documentation of the incident, investigation and root

causes was comprehensive, open and honest. We also saw that the patient's family had been communicated with and offered apology in line with the duty of candour principles.
- We saw there were recent governance newsletters and lessons learnt displayed on notice boards in the cardiology wards, for staff to read.
- Clinicians attended regular mortality and morbidity meetings to take part in and learn from discussions of specific cases, including near misses. A number of clinically led speciality groups, which met every three months, regularly reviewed mortality of medical patients.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring analysing patient harms and 'harm free' care. All the medical wards recorded the Safety Thermometer information monthly.
- Some wards displayed their safety thermometer information for patients and visitors to see, but some did not.
- For the period July 2014 to Jul 2015, across the trust, there were 201 pressure ulcers Grade 2, 3 or 4. The prevalence rate showed a steady decline between November 2014 and July 2015.
- There were 261 falls and the prevalence fluctuated over the year however, in July 2015, it was four times higher than July 2014.
- There were 98 catheter urinary tract infections and since August 2014, there has been a general downward trend of the prevalence rate.

Cleanliness, infection control and hygiene

- Overall practice in relation to infection prevention and control (IPC) was good; however, we saw some examples of poor practice.
- Hand-washing facilities were available throughout the wards and we observed hand gel dispensers at the entrance to the ward, each bay and side room.
- We observed staff complying with bare below the elbows policy, correct handwashing technique and use of hand gels in most of the areas we visited.
- We observed staff using PPE including face protection in the dialysis unit and patients with blood borne infections were always cared for in cubicles.
- Patients commented that staff always wore aprons and gloves and they saw them washing their hands and using hand gel.
- However, we saw staff moving from bay to bay on Hadfield 5, which was the Clostridium Difficile (C.diff) cohort ward, with the same apron and gloves on and not always washing or gelling hands when they should. We also observed domestic staff on Hadfield 1 cleaning bed spaces and sinks in a number of bays without changing gloves or cloth between areas.
- We observed doctors washing hands between patients during a ward round on AMU.
- We observed Methicillin Resistant Staphylococcus Aureus (MRSA) colonised patients appropriately isolated in single rooms and other patients barrier nursed in a bay if there were no single rooms available. If patients with infections were barrier nursed in side rooms, there were visible STOP warning signs on the doors. There was information displayed for visitors and we saw nurses explaining to them the need for personal protective equipment (PPE) such as aprons and gloves.
- Patient washing bowls were lined with a waterproof bag prior to use. We did not observe bowls being cleaned between use although the liners were changed for each patient. We observed a member of staff carrying a bag full of dirty water from a washbowl across the corridor into the sluice; this was a safety risk as the bag was unsupported.
- Appropriate containers for segregating and disposing of clinical waste were available and in use across the departments and we saw that PPE, used linen and waste was disposed of correctly.
- In the main, we saw that sharps were disposed of safely and correctly; however we did observe a member of staff carrying used sharps through the ward area.
- The wards at NGH participated in the SHFT "Infection Control Accreditation Programme" which set standards for infection prevention and control practice. The programme aimed to optimise and assess infection prevention and control practices in clinical teams and comprised of a regular audit schedule using bespoke audit tools. Areas audited were; hand hygiene, cleanliness of commodes, high impact interventions, standard precautions, mattresses, aseptic technique, disposal of linen and anti-microbial prescribing. Wards had to achieve three consecutive months of audits at 95% compliance or above and had to have a named infection prevention champion.

Medical care (including older people's care)

- All of the medical wards had current accreditation with the exception of Osborn 3 and the endoscopy unit who were 4-6 months overdue at September 2015. Both of these areas were working towards re-accreditation. Part of the accreditation was that wards and departments must have a link nurse for infection control who could attend meetings and cascade information to the rest of their team.
- Patients commented that the wards were clean and hygiene standards were good. They said they saw domestics wearing appropriate PPE and cleaning bed rails, bed edges and tables.
- We did observe in AMU and the frailty unit that computer keyboards were dusty or dirty.
- There were six cases of MRSA infection / colonization attributed to the medical services at NGH, between April 2015 and July 2015 and no cases of bacteremia during this time.

Between April 2015 and July 2015 there were nine cases of C.diff attributed to the medical wards at NGH and a further 11 associated cases.

Environment and equipment

- The environments in the ward areas were visibly clean and well maintained. Daily cleaning checks were displayed and up to date.
- Results in the Patient-led Assessments of the Care Environment (PLACE) the trust consistently had higher scores than the England average in all four sections over the last three years. In 2015 SHFT achieved a cleanliness score of 100% against the national average of 98%, a food score of 93% against the national average of 88%, privacy and dignity score of 90% against the national average of 86% and a facilities score of 94% against the national average of 90%.
- A site overview assessment of NGH using PLACE criteria (Feb 2015) showed that improvements were needed on some wards with regard to being "dementia friendly". Common issues related to signage, flooring, lack of contrast colour for toilet doorways and seats were found on Firth 2, 6 and 7, Brearley 2 and 4, Huntsman 5, Robert Hadfield 1, 4 and 6, Chesterman 1, 2 and 3.
- All wards met the standard for the other criteria relating to food, cleanliness, privacy and dignity and maintenance.
- Staff raised concerns regarding the layout of the Hadfield wards and the lack of visibility of some of the bays and single rooms. Staff felt that the lack of visibility had a direct impact on the number of falls occurring in some areas.
- Staff on Huntsman 5 felt the environment was not suitable for the throughput of patients since it became a short stay ward. We observed the environment was cramped and not all areas were visible. Side wards did not have dedicated or ensuite toilets therefore infected patients had to use commodes. There was no sitting area for patients and a lack of storage space.
- We saw that due to the closeness of beds to each other and one bed very near the nurses' station in AMU that patients could overhear potentially confidential conversations between staff.
- Staff said that equipment to meet patient needs was available.
- Resuscitation trolleys were available along with portable oxygen and suction. We saw that in most cases, daily and weekly checks of this equipment were up to date, and that trolleys were clean.
- Other equipment such as commodes, hoists and mobile computers were visibly clean and labelled as ready for next use.
- Specialist equipment on the renal unit was serviced by the biomedical engineering dept. and the renal technicians would come straight away if there were problems with the machines. There were stickers on all the machines for servicing records.
- We observed a patient fridge in the dining area on Hadfield 1 that did not appear to have daily checks of temperature or contents.

Medicines

- Patients told us they received their medicines regularly and on time.
- Controlled drugs were appropriately stored with access restricted to authorised staff and accurate records kept. Staff performed daily balance checks in line with the trust policy.
- We reviewed 29 medication administration records. We saw that patients received their medicines in a timely way, as prescribed, and that records were completed appropriately. There were a small number of records (six of 29 charts reviewed) where antibiotic review or stop date was not recorded.

- We observed three patients receiving oxygen therapy without a prescription. Prescribing of oxygen therapy was on the trust risk register and new prescription charts were being piloted and audited between October and December 2015. The aim of the new documentation was to improve compliance with the correct prescribing of oxygen therapy. We saw two examples of patients who were managing their own medicines on Brearley 1, however their ability to self-medicate had not been assessed and assessment documentation had not been completed. This meant that we could not be sure that patients were able to take their own medicines safely or effectively and that staff were not following the trust policy on self-administration.
- To ensure the safety and effectiveness of medicines, fridges must stay within the temperature range of 2-8 degrees Celsius. In most areas, we saw that minimum and maximum fridge temperatures were recorded daily and were within the correct range.
- We saw that in some areas intravenous fluids were stored safely and securely in locked cupboards or rooms. However, in other areas storage was of concern. Doors to medicine rooms on the frailty unit, Huntsman 2, Brearley 1, and Brearley 5 were unlocked meaning that access to fluids was not restricted to authorised staff. The trust advised this had been raised as a trust wide issue at Medicine Safety Committee and the issue was logged on the appropriate risk registers for the directorates and at trust level. There was a plan in place to ensure all new major schemes will have swipe card access to areas where access need to be restricted and a business case was being prepared for this to be implemented across the Trust.
- We found 22 bags of intravenous fluids (5% glucose) out of date on Hadfield 1. Staff were informed of this and appropriate action was taken to dispose of the fluids.
- We checked medicines and equipment for emergency use and found that they were readily available, stored appropriately, and that regular checks had been performed to ensure that they were fit for use in line with the trust policy.
- We observed on some wards that one nurse was checking and signing for intravenous fluids; this was against the best practice guidance within the trust policy. The NMC Standards for Medicines Management states, "wherever possible two registrants should check medication to be administered intravenously, one of whom should also be the registrant who then administers the intravenous medication". (NMC, 2010, page 10, standard 20).

Records

- Patient's records were a combination of both electronic and paper records. A range of risk assessments were included within the records for example; falls, manual handling, Waterlow, nutrition and body mass index (BMI), bed rails, early warning scores and neurological observations to manage the deteriorating patient.
- At NGH, we looked at 17 care records and 29 medicine prescription / administration cards. Overall, we found documentation to be of a good standard although there were a small number of gaps. The main gaps were regarding nutritional assessment not recorded (five out of 17 records) and incomplete documentation of care plans / care needs in three out of seventeen records.
- We looked at nine sets of records on the Hadfield wards where patients had a do not attempt cardiac pulmonary resuscitation (DNACPR) in place and found eight fully completed with discussions recorded. One patient's record, however, had a DNACPR form that was completed and signed but no discussion, with either the patient or relative, recorded. Neither was a reason given for why a discussion had not taken place.
- There were evidence based nursing care guidelines, which fulfilled the function of care plans, available for reference for a wide range of possible care needs. However, these were not printed and available at the patients' bedside or with the patients' care record. Some wards had printed reference files available for staff to use, however we did not observe staff using these. Other wards referred us to the intranet to view these guidelines and again we did not observe staff referring to these. Staff told us computers were not always easily accessible and that new, bank and agency staff did not always have an individual log on. This meant that care plans / guidelines were not always accessible for staff delivering care. We felt this posed a potential risk to effective care delivery and there was a potential for elements of required care being forgotten, missed or incorrect care being given. It was unclear how staff or the trust could be fully accountable for care given when the relevant guidelines were not easily accessible to all staff providing care and were not held as part of the contemporaneous records.

Medical care (including older people's care)

- The risks above were mitigated to some extent by a tracker sheet, which referenced the care guidelines applicable to each patient. The tracker sheet was an integral part of the patient record.
- The risk was also, less where staff used a documented handover, which was electronically stored and printed for staff use. However we observed that not all wards were using formal handover sheets and in some areas planned care was communicated verbally at handovers.
- New documentation had recently been introduced for initial medical assessment and subsequent senior medical reviews. These were documented on separate colour coded forms, which were easy to identify. Assessments were thorough and easy to follow. There was good documentation of investigations and results.
- The new documentation was to be audited to evaluate its effectiveness and staff compliance with its use.

Safeguarding

- There was a dedicated lead for safeguarding and staff were aware of this. Staff we spoke with were able to give examples of recent safeguarding issues and how they had been dealt with.
- Staff were clear how to escalate safeguarding concerns and had a good understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Staff knew who the safeguarding team were and how to contact them when they needed advice or support.
- Staff had good links with the mental health crisis team and the vulnerable adults' team.
- The multidisciplinary team (MDT) undertook MCA assessments and held best interest meetings when needed. Independent mental capacity advocates (IMCAs) were involved where needed and staff knew how to access this service on behalf of patients.
- We looked at nine sets of records where patients had a cognitive assessment. These were all fully completed, legible, dated and signed.
- Four out of nine reporting units had exceeded the 75% Q1 target for adults' safeguarding training compliance for nursing staff. None of the reporting units had achieved the 90% Q2 target.
- Nursing staff compliance with children's' safeguarding training at level one was above the trust 90% target for all services except Gastroenterology at 88% and Emergency at 44%. Compliance with children's' safeguarding training at level two was below the trust 90% target for all services except Neurosciences and Specialised Rehabilitation.
- Compliance with adult safeguarding training for medical staff at NGH was between 7% and 78% with none of the services achieving the trust target of 90% by the end of quarter 2. Specialised rehabilitation was the only service to exceed the quarter 1 target of 70% by the end of quarter 2. The other seven reporting services achieved 48% or less.
- Compliance with children's' safeguarding training at all levels was below the 90% trust target for medical staff across all medical services. Very few services had reached the quarter 1 target of 70% by the end of quarter 2.

Mandatory training

- Most of the staff we spoke with told us they were up to date with their mandatory training.
- At NGH, mandatory and statutory training data showed that many areas had exceeded the 70% quarter 1 target but only about one third had reached the 90% quarter 2 target. There were some areas where compliance with specific modules of training was poor. For example, compliance in integrated stroke and geriatric medicine was poor for infection prevention and control, basic life support and moving and handling. Several other areas also had poor compliance for moving and handling.
- Staff told us they had a two-week intense induction when they started working at the hospital and that they received regular emails with training dates for other mandatory training.
- Medical staff groups across this service were not compliant with the trust target of 90% for quarter 2. Only a few areas had reached the 70% quarter 1 target, by the end of quarter 2.

Assessing and responding to patient risk

- All patients were routinely risk assessed on admission and these were on the electronic patient record system.
- All wards used the SHFT early warning score (SHEWS) system to identify patients whose condition was deteriorating. Nurses recorded observations appropriately and escalated concerns in accordance with the guidance.

- We saw there were standard operating procedures and escalation procedures displayed for managing the deteriorating patient. The staff we spoke with were able to explain the procedures for managing the deteriorating patient.
- We saw in the records we reviewed that deteriorating patients were identified clearly and escalation instructions were documented. We also saw that calls to doctors had been made when SHEWS had indicated deterioration in the patient's condition. In one set of records, it was not clear what response the medical team had made.
- SHEWS audits were undertaken on a monthly basis to ensure that: Trust policy is adhered to, recognition of acute deterioration is documented appropriately, SHEWS are accurately calculated, patients who trigger are appropriately communicated and escalated to the medical team in a timely way, patients who trigger receive close monitoring as per policy and receive a full assessment. The audit also noted whether the patient's condition improved and if not, whether they received further assessments and treatment and were escalated to a senior trainee doctor or consultant. Audits also covered whether there was a management plan in place.
- Audit data was entered into e-CAT, the trust Clinical Assurance Toolkit. The ward manager or a delegated deputy followed up any issues highlighted at a local level.
- We looked at nine sets of records on the Hadfield wards, which showed that risk assessments were fully completed and a consultant review had taken place within 24 hours.
- All members of the hospital at night team held bleeps so the night coordinator could alert staff when a patient's SHEWS was deteriorating and needed immediate assessment or if any tests or blood samples were needed.
- All patients were risk assessed for falls, nutrition and hydration and for skin pressure damage. Patients at high risk were red flagged to ensure this information was handed over at shift changes.
- Patients told us that they felt safe and that staff monitored them regularly. A patient on AMU told us they were checked every two hours.
- On Brearley 7, the dementia unit, one bay was allocated to patients at high risk of falls to ensure they could be observed more closely and staff risk assessed patients before allocating them to side rooms, as these were not readily visible.
- The male bay on Brearley 7 had five beds instead of the usual six as male patients suffering from dementia were more prone to being aggressive, this enabled a better ratio of staff to patients and improved patient safety.

Nursing staffing

- STHFT used the national "Safer Nursing Care Tool" to determine the number and skill mix of staff needed on the medical wards based on acuity and dependency of patients. Ward managers told us that patient acuity and planned staffing levels were reassessed every six months.
- Staff told us that at times there were not enough staff on duty, but they could get bank staff or staff would work additional hours if they were available. Matrons monitored staffing levels and workload demand regularly throughout the day and staff were moved from one ward to another if this was necessary. Although staff did not think this was ideal, they understood why this needed to happen and appreciated the help they received from other wards when they were struggling.
- We looked at staffing fill rates for the medical wards (all sites) May 2015 - August 2015 and found that overall, the fill rate for registered nurses (RNs) was between 88% and 95% and the fill rate for support staff was between 102% and 120%.
- The data for fill rates demonstrated that although on the majority of occasions extra health care assistants (HCA) were in place to mitigate for fewer qualified nurses, this was not always possible.
- At NGH, qualified staffing levels fell to between 70% and 80% on wards Brearley 4, 5, 6, and Robert Hadfield 6 in June 2015, Brearley 4 in July 2015 and Brearley 4, 5 and Robert Hadfield 5 in August 2015. During most of the periods of fewer qualified nurses, it was evident that extra support workers had been available to provide cover where possible.
- Some wards had more vacancies than others did and staff told us that certain areas such as Hadfield 2 and Huntsman 5 had difficulties recruiting.
- Managers for the medical services told us that the areas most affected by staffing shortages were geriatric and

stroke medicine and spinal injuries. They told us there were approximately 30 whole time equivalent vacancies in this area, although this did include community staff and some staff based at RHH.

- Staffing issues were exacerbated on Huntsman 5 as this had been a temporary winter pressure ward and therefore was not attractive to staff wanting a permanent post. As this was now a permanent ward, the ward manger hoped that this ward would be more attractive as a place to work.
- There had been some recent recruitment of newly qualified nurses from Spain into this area but staff told us this did cause additional work, initially, as the experienced nurses needed to supervise the newly qualified staff.
- The trust operated a staff transfer register, where staff could register a wish to move to a post in a different area. This was well received by some staff but others felt that this exacerbated staffing difficulties in the less popular areas.
- There were four full-time RN vacancies on Hadfield 2 and nine on Huntsman 5. Staff told us they could book agency staff if needed but that shifts were not always filled.
- In areas where there were vacancies, staff reported that they did what needed to be done but were not able to provide the standard of care they would have liked, or spent as much time with patients as they would have wanted.
- Senior managers were well aware of the risks of staffing shortages and were trying to address this as far as possible by proactively recruiting from abroad, undertaking recruitment activities at local universities and by over recruiting to HCA posts to assist the RNs where this was appropriate.
- During the inspection week, there were four qualified nurses on duty in the morning against a planned number of five on Huntsman 5. As one of the nurses acted as ward coordinator, this meant a ratio of 11 patients to one nurse. Ratios were even higher during the night as there were only three RNs on duty.
- Ward managers were able to book bank and agency staff for shortfalls in advance and at short notice, although it was not always possible to fill shifts.
- There was an escalation plan in place for staff to implement when they were faced with an acute staffing issue and matrons continually assessed risk across a number of wards so they were able to move staff if needed. Matrons and senior nurses also worked on the wards if necessary to maintain patient safety.
- Patients told us that they did not always feel there was enough staff, as they appeared very busy and overworked at times.
- AMU staff told us that they needed to use bank staff regularly to cover shifts.
- Although the ward manger tried to roster an additional member of qualified staff during the night on the gastroenterology ward for the "gastric bleed rota", this was not always possible. Staff on the gastroenterology ward told us they could be left with only one RN for periods during the night if a nurse had to attend an emergency endoscopic procedure. However, they could contact the bleep holder or site manager to find them additional support if this was possible.
- We observed a number of nursing handovers and found that communication was clear, comprehensive, and included information about staff sickness, patient transfers, and ward issues. However, handovers were generally verbal with little in the way of written communications. In some areas, nurses made their own notes from the verbal information given.
- We saw the cardiology wards used an electronic handover and nursing and medical staff updated this throughout the day.

Medical staffing

- Medical staffing skill mix across the trust was similar to the England average. Consultants, middle career and registrar groups made up 32%, 3% and 46% respectively of the medical workforce and junior doctors 19%. The England averages were 34%, 6%, 39% and 22% respectively.
- There was medical cover for all specialties Monday to Friday between 8.30am and 8.30pm.with a multi-disciplinary hospital at night team with the ability to call in specialist expertise when needed. Most specialties had consultant's onsite at the weekend between three and 10 hours on Saturdays and Sundays. Twenty-four hour, seven-day on-call cover was available in all specialties outside of these hours.
- At NGH, the hospital at night team covered medical admissions and inpatients between 8.15pm and 9am. The team consisted of two general medical staff grade registrars or specialist registrars (SpRs), four foundation

year two doctors (FY2) (or more senior doctors) and two foundation year one (FY1) doctors. The night team included additional members of staff including advanced nurse practitioners and support workers.
- The night team remained on duty until 9am, for emergency calls, to enable the day doctors to do post take ward rounds uninterrupted.
- Junior doctors confirmed that consultants were easily accessible if needed and that acute medical consultants were regularly called into the hospital at night.
- We observed a day to night medical handover. The handover was led by the SpRs and was organised and well structured. The advanced nurse practitioner (ANP) triaged all outstanding jobs and allocated them to the most appropriate staff member i.e. doctor, ANP or clinical support worker (CSW). This ensured the most urgent patients were dealt with first. All wards and patients were reviewed and all patients identified as 'at risk' were discussed.
- Handover of poorly patients included what had been done and what results were expected as well as what the plans were for interventions, pending results of investigations. The handover also indicated that patients' wishes had been considered. Handovers were made using the situation, background, assessment, recommendation technique (SBAR). Newly admitted patients waiting to be assessed and clerked were also highlighted.
- We observed that the SpRs were competent, professional and supportive of junior doctors.
- However, the night to day handover we observed appeared unstructured and disorganised Doctors were coming and going throughout and did not communicate well and it was not clear who was handing over to who. Bleeps went off twice and consultants opened the door to the handover room a number of times to call junior doctors out into the corridor to provide information or ask questions. The door was open for a period while patient discussions were taking place. Some doctors handed over to another individual in "huddles" around the room. We did see individual doctors hand patients over effectively and discuss; ceilings of care / end of life guidance, DNACPR and priority patients. The night coordinator told us that printed handover sheets were available for consultants however; we did not see these used.
- We saw how SHEWs information and tasks came through to the electronic board in AMU and that the coordinator and members of the team could easily see this information. The most appropriate member of the MDT undertook jobs from the list in order of clinical priority. The advanced nurse practitioner acted as coordinator overnight and could bleep the support workers or doctors, as appropriate when new tasks came through or when SHEWS indicated a patient deterioration on one of the wards.
- Specialist registrars told us they received good support from their consultants. Senior house officers and foundation year one doctors were ward based which they told us in the main, worked well however this could create challenges for senior house officers (SHOs) contacting the correct SpR, when they were covering two or three specialities.. Junior doctors told us there was good team working and cross cover among the geriatric teams.
- There was little locum use across the medical specialities with between 0% and 4.4% use across the specialities. Gastroenterology and respiratory medicine were the highest users of locum support at just over 4%.
- Sickness rates for medical staff were low at 2% or less across all services.
- Vacancy rates for medical staff were low across most services with gastroenterology, specialised rehabilitation and communicable diseases and specialised medicine being the worst affected areas at 12%, 16% and 15% respectively. Musculoskeletal services and neurosciences had vacancy rates of 5% and 4% with other services
- Staff on the medical wards told us consultant ward rounds took place every day and patients commented that a consultant saw them every day.
- Support workers assisted the medical teams with tasks such as cannulation, blood sampling and ECGs.
- Medical staff were present on the AMU and frailty admission ward day and night. Consultants were present 8am until 8pm and were called in outside of those hours when necessary.
- Staff told us there was good medical staffing on CCU; if the cardiology registrar was tied up in cardiac catheter laboratory then the on call registrar would cover the unit. Consultants in cardiology reviewed level two and three patients twice a day.

Major incident awareness and training

Medical care (including older people's care)

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

Clinical leads told us that consultant cover would be increased over the Christmas period to support with the anticipated increase in demand.

Are medical care services effective?

Good

We rated effective as good because;

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

However;

- Appraisal rates for both nursing and medical staff were below the trust's targets.

Evidence-based care and treatment

- Policies and pathways were based on national institute for health and care excellence (NICE) and Royal College of Physicians guidelines and were available to staff and accessible on the trust intranet site.
- Staff demonstrated awareness of policies, procedures and current guidance. They knew how to access this information on the trust intranet and on the ward.
- All doctors took part in clinical audit and each speciality had an audit lead.
- Ward staff had access to specialist nurses for additional support, training and expertise. Specialist nurses included; heart failure nurses, asthma / respiratory nurses, diabetes specialists, pain specialists and others.
- Matrons audited wards against compliance with a number of 'nurse sensitive' quality indicators such as staffing, sickness, appraisals, capacity, friends and family test, patient harm and infection control practice. This helped identify areas where improvements were needed and wards were supported with any action needed.

Pain relief

- A patient's family told us that they had accessed support with pain control from the MacMillan team and ward staff had given complementary treatments such as heat treatment as a method of relieving pain.
- We observed nurses asking patients about pain and the need for pain relief during two-hourly comfort round.
- Patients told us they received pain medication when they needed.

Nutrition and hydration

- Nursing staff used a nutritional screening and assessment tool incorporated into the patient admission record to assess patients' nutritional needs and risk factors on admission.
- Patients could choose from a range of options which included healthy choices and special diets such as gluten-free or diabetic and soft diets
- Patients we spoke with told us that the food was good or acceptable.
- We saw that patients assessed at risk of malnutrition were given food supplements.
- We saw that drinks were available within reach of patients most of the time and that staff provided patients with assistance to eat and drink when needed.
- We observed patients in the discharge lounge were given drinks and offered meals at lunchtime.

Patient outcomes

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

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

- In the Heart Failure Audit 2013, NGH had a mixed performance for in-hospital care indicators; it performed better than the England average for input from specialist and echocardiogram, and worse for consultant input and cardiology inpatient. NGH performed worse than the England average for four of the discharge indicators and better than the average for the other three indicators. The trust informed us that all patients receive consultant input either directly or through MDT meetings where cases are discussed and felt strongly that data quality issues had affected the reported outcomes above. The medical service was working to improve data coding and input for future audits.
- The MINAP audit 2014 showed there was an increase from 2013 in the number of NSTEMI patients seen by a cardiologist, admitted to a cardiac ward, and referred for or had angiography. However, the percentages had decreased from 98.9% to 93.5%, 71.8% to 60.7% and 66.5% to 63.3% for the respective indicators. In 2014, the number of patients seen by a cardiologist was slightly lower than the England average of 94.3%. Patients admitted to a cardiac ward was above the England average of 55.6% and patients referred for or had angiography was lower than the England average of 77.9%. The trust explained that patients from smaller district general hospitals attending NGH for Percutaneous Coronary Intervention (PCI) adversely affected the figure for patients referred for or had angiography, as this would have happened at the referring hospital.
- In the National Diabetes Audit 2013, NGH performed better than the England median in 13 indicators and worse than the England median in the other eight. The areas highlighted for improvement included; visit by a specialist team, foot risk assessment, able to take control of diabetes and staff knowledge. Additionally the trust has undertaken a number of other actions to improve outcomes for diabetic patients. The trust aims to review the structured education, restructure the adolescent pathway, improve on BP and cholesterol targets and improve the percentage of patients completing all eight care processes.
- Staff told us that one of the diabetic specialist nurses saw all new type one insulin dependent diabetic patients and that this team worked at weekends. Some of the wards had a diabetic link nurse and training days were available four times a year.
- The trust had undertaken a self-assessment against the recommendations from the National Pain Audit. The MSK service had used these recommendations to develop a 5-year plan to improve pain services.
- At a trust level, the standardised relative risk of readmission in elective admissions was higher than the England average. The top three specialties with the highest count of activity were clinical oncology, medical oncology and clinical haematology and they all had a rate around one third higher than the England average.
- NGH had a lower rate of elective readmissions than the England average for gastroenterology and higher readmission rates for cardiology and nephrology.
- The trust's standardised relative risk of readmission for all non-elective admissions is in line with the national average. However, NGH had a higher readmission rate overall for non-elective readmissions and for respiratory and geriatric medicine. NGH had a lower readmission rate for general medicine.
- Performance and quality of care was monitored on all wards using nurse sensitive indicators: complaints, incidents, infection control, falls, MRSA, C.diff and drug errors.

Competent staff

- Staff at SHFT received an annual appraisal to facilitate personal development and maintenance of skills and competence. The target for nursing and medical staff groups was that 85% of staff would have received an appraisal between April and September 2015.
- Appraisal rates for nursing staff were split by speciality and were above 85% for renal, neurosciences and specialised rehabilitation. Cardiothoracic, respiratory and gastroenterology services were between 72% and 82%. Trust data indicated that communicable diseases and specialised medicine nursing staff had not had any appraisals and geriatric and stroke medicine on this site had a rate of 37%. (April -September 2015).
- Appraisal rates for medical staff in this core service were split by speciality and only available at trust level as doctors may work across more than one site. Most specialities had appraisal rates above 75%; however,

gastroenterology, therapeutic and palliative care, cardiothoracic and renal services had appraisal rates of 53%, 60%, 68% and 73% respectively, for the period April 2015 to September 2015.

- Most of the staff we spoke with told us they had received an appraisal in the last 12 months.
- There were various educational forums for medical staff to attend such as a breakfast club held in the speciality of endocrinology. Other specialities provided mini training sessions in the ward environments. Junior doctors felt that education and support was good. Junior doctors from the renal services in particular thought that standards of education and support were excellent.
- There were practice educators on some of the wards. Evaluation of this role indicated that the post had increased competency, retention of staff, safety and morale.
- The pharmacist responsible for the diabetic ward Hadfield 1 had received additional training about diabetes.
- There were nine nurses in the medical assessment centre undergoing a two-year master's degree programme to become advanced nurse practitioners, competent to undertake medical assessments and initiate investigations and treatment. Clinical support workers in the hospital at night team had been trained to undertake clinical tasks such as cannulation, venepuncture and ECG.
- Staff in the cardiac catheter laboratory had undergone various competency assessments and advanced life support training.
- Clinical support workers on the wards told us they had been through a two week 'prepare to care' course when they started work at the hospital. This gave them all of their mandatory training and taught them skills they would need on the ward. Training included practical caring skills and use of basic equipment.
- When new staff were allocated to wards they were allocated a mentor and underwent a period of shadowing more experienced staff before they worked unsupervised.
- We observed teaching and learning taking place during ward rounds. Consultants clearly explained their thought processes and diagnostic assumptions to the junior doctors present.
- A new member of the physiotherapy team told us they had a six week period of supervision from an experienced member of the team and was able to access weekly 'in team' training. New staff also underwent competency assessments before being left unsupervised.

Multidisciplinary working

- We observed good multidisciplinary working in all areas and staff spoke very positively about working relationships with members of the multidisciplinary team (MDT).
- We observed multidisciplinary board rounds on a number of wards. These were an effective discussion of the patient's condition, progress and plans and all members of the team were involved in the discussion. We saw that all members of the team were involved in best interest decision-making.
- Participants in ward rounds included physiotherapists, occupational therapists, pharmacists, in-reach nurses and hospital based specialist nurses.
- Consultants told us there were many different types of multidisciplinary work, which involved discussion with other specialists from both within the hospital and with consultants from other hospitals across the region.
- Pharmacists were allocated to wards and took part in multiagency discussion to help prioritise the needs of new patients, reconcile medications from community to hospital, facilitate discharge and flag any pharmaceutical issues such as omitted doses or prescribing errors.
- Patients told us they had received input from many different professionals in hospital and that they would have multidisciplinary follow up when they returned home. A stroke patient told us carers had been arranged and that she would receive speech and language therapy at home.
- A patient told us how the asthma nurse specialist had collaborated with her GP to ensure medications were correct and how she liaised with other specialists when she needed professional advice.
- We saw that patients attending AMU who had taken a deliberate overdose were offered psychiatric referral and were asked about what support they were already receiving. The AMU pharmacist routinely took part in ward rounds and was able to offer advice regarding managing medications when a patient had accidently overdosed.
- Renal patients had good access to psychological support

Medical care (including older people's care)

- Patients attending AMU were asked about home circumstances and multiagency support already available or potentially needed to enable effective discharge.
- There was in-reach to the gastroenterology wards from an alcohol liaison officer provided daily admission checks to facilitate follow up in the community.

Seven-day services

- All medical specialties at Sheffield Teaching Hospitals Foundation Trust (STHFT) had a 24 hour, 7 day a week emergency service. There were separate specialities for geriatric and stroke medicine, diabetes and endocrinology, gastroenterology, respiratory medicine, acute medicine, neurology, haematology, infectious diseases and acutely unwell patients were admitted under the appropriate speciality team.
- In addition to the admitting medical teams, there were nominated staff / wards that provided support for out of hours emergency services. For example, the gastroenterology ward had additional staff overnight to enable them to attend and deal with patients who had a gastrointestinal bleed and needed an emergency endoscopic procedure.
- The front door response team and discharge teams provided seven-day cover to AMU and the medical wards.
- There was seven-day therapy and pharmacy provision for the AMU and frailty admission unit.
- Medical patients had access to seven-day diagnostic and imaging tests.

Access to information

- Medical, nursing and allied health professional staff had access to patient information, risk assessments, test results and diagnostic images via electronic systems, which were accessible on all medical wards and departments.
- There were some issues with the new electronic patient record system, which was exacerbated by administrator vacancies in some areas. The patient record system did not connect to the electronic whiteboard system, which meant that information needed to be specially uploaded or input on to a second system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were aware of how to gain both written and verbal consent from patients and their representatives. Members of the MDT usually undertook mental capacity assessments and best interest decisions in discussion with each other.
- Patients told us that the nurses always told them what they wanted to do and always asked for permission first before starting tasks or personal care.
- Staff had a clear understanding of consent, mental capacity and deprivation of liberty safeguards.
- Staff received training about Mental Capacity Act and DoLs, as part of their safeguarding of vulnerable adults training.

Are medical care services caring?

Good

We rated caring as good because;

- We observed staff in all areas treating patients with kindness and respect.
- Privacy and dignity was maintained at all times and we saw staff answering patients' questions patiently and cheerfully with a caring manner.
- Patients were very happy with their care from all professional groups and told us staff had gone out of their way to ensure their comfort and dignity.
- Patients told us they were involved in decision-making and felt listened to.

Compassionate care

- We observed staff in all areas treating patients with kindness and respect.
- Staff spoke to patients in a reassuring manner and maintained privacy and dignity when delivering personal care. We saw staff answering patients' questions patiently and cheerfully with a caring manner.
- Patients we spoke with told us the experience had been very good, the staff were extremely caring, courteous and knowledgeable.
- Patients had observed nurses keeping an eye on other patients and being proactive with care in response to physical signs of patients looking tired or unwell.
- Volunteers and staff told us they would be happy for their relatives to receive care at this hospital.
- Patients told us that staff always said good morning and knew their preferred name. Doctors and nurses

introduced themselves and told patients why they were there. Patients said they were treated well. One patient on Huntsman 5 told us a support worker had gone out of her way to find her a comb and some toiletries when she realised she did not have anything with her.

- We observed a caring and inclusive manner among doctors during ward rounds.
- Relatives we spoke with on Hadfield 2 told us that the end of life care was excellent. The patient's family had been accommodated overnight to be with them at all times. Staff always checked the patient's family were offered food and drinks and that they took breaks from the ward. Staff had obtained a free parking permit for the family. Care was personalised and communication was positive.
- Patients commented that the doctors' bedside manner was very good. Patients felt staff had protected their dignity, pulling curtains, keeping them covered and encouraging them to be independent where they could.
- Staff carried out regular comfort rounds asking patients if they were comfortable or had any pain. Other needs were also checked at this time such as if drinks were needed or if the patient needed assistance going to the toilet or with changing position.
- We observed staff closing curtains and doors to maintain confidentiality and privacy.
- Patients told us that staff in AMU were flexible about visiting times.
- We heard of one occasion where a patient had broken their phone and could not contact a friend to bring in a key so they could go home. A member of staff gave the patient an old phone and the operations manager called at the friend's home to collect the patient's key.
- The medical service at this hospital had a Friends and Family Test response rate of 36 % between July 2014 and June 2015 that was better than the England average of 34.5%. Huntsman 5, Brearley 1, Brearley 2 and Firth 6 were the only wards, with over 100 responses not managing to achieve a response rate higher than the England average during this time. The average response rates for these wards were 17%, 33%, 34% and 24% respectively.
- More recent data; for October 2015 showed that NGH had an average recommendation score of 95% in the NHS Friends and Family Test, which was the same as the England average. Six of the medical wards had a recommend rate of less than the England average during October 2015; however, all of these had over 90% of patients recommending their service. Robert Hadfield 5 had a recommendation rate of 80%; however, this was likely to be skewed by the low response rate of 5.1%. One out of 10 patients on this ward said they would be unlikely to recommend.
- SHFT 'Frequent feedback inpatient results' (April 2014 to March 2015) showed that overall patients thought that care on the medical wards at NGH was excellent / very good and that they were always treated with dignity and respect. Involvement of patients in decisions about their care was rated as poor for the Robert Hadfield wards 1, 3, 4, 5 and 6 and patients on Robert Hadfield 4 and 6 indicated they did not always receive the help they needed to eat and drink. Patients in all areas indicated that they received enough help with toileting and hygiene needs.
- Of the 34 indicators in the Cancer Patient Experience Survey, the trust is in the top 20% for three indicators, the bottom 20% for one indicator and in the middle 60% for the remaining 30.
- In the CQC In-patient Survey 2014, the trust is performing about the same as other trusts for 11 of the 12 indicators.

Understanding and involvement of patients and those close to them

- Patients and relatives told us they were well informed and were involved in decisions about care.
- Patients were involved in evaluating the effectiveness of their own treatment such as when medication doses where changed. Doctors listened to their opinion.
- Patients told us that they were always asked what they wanted regarding their care and treatment and they felt that they had a choice.
- Patients understood what was happening to them and why. "Staff are very busy but efficient and they go to great lengths to explain everything."
- Doctors kept patients informed of any delays in investigations or treatments and informed them of multidisciplinary discussions and decisions.
- Patients said they could ask staff anything if they did not understand or they needed something and this helped them feel safe.
- Family members of a dying patient told us that care had been very personal and patient and family wishes were always taken into account.

Medical care (including older people's care)

- Relatives told us that ward managers were accessible, approachable, and gave good information.

Emotional support

- A patient on Huntsman 5 told us that staff gave them emotional support. "If they think you are upset, they will sit with you and hold your hand and try to cheer you up."
- We observed staff comforting patients who were visibly upset.
- Clinical nurse specialists were available for a range of services such as learning disability, infection prevention and control, tissue viability, and cancer care.
- There was a chaplaincy service across the trust.

Are medical care services responsive?

Good

We rated responsive as good because;

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

However

- High numbers of patients were moved to a ward outside of their speciality ward and 20% patients were moved twice or more during their hospital stay.

Service planning and delivery to meet the needs of local people

- There were many examples of service planning and delivery to improve services for patients. For example, work was ongoing to improve front door access to services and improve discharge, community and integrated geriatric and stroke medicine had recently merged into one care group to improve integrated pathways of care for elderly patients to enable better care at home and in the community.
- There was ongoing work with other hospitals in the area regarding provision of specialist services such as stroke and renal medicine.
- Patients commented on the new AMU and said it was much improved, corridors were nice and wide and signs were clear and easy to follow.

Access and flow

- The average length of stay in this hospital was shorter (better) than the England overall average for elective medical patients, 3.6 compared to 4.5. The length of stay for the three top specialties were; spinal injuries 12.3, cardiology 1.1 and adult cystic fibrosis 9.5. These were also better than the England averages for these services, which were 17.0, 1.9, and 1.3 respectively.
- The average length of stay in this hospital was longer (worse) 8.2 than the England overall average of 6.8 for non- elective medical patients and in the specialties of geriatric medicine and respiratory medicine but better than the England average for general medicine. The length of stay for geriatric patients was 13.9 compared to the England average of 10.1, respiratory patients length of stay was 8.1 compared to 6.9 England average. However, general medical patients had an average stay of 3.6 compared to the England average of 6.4.
- Non-elective / emergency patients were predominantly admitted from the accident and emergency department (A&E) to the Acute Medical Unit (AMU). The unit also accepted admissions via GP referral to the servicer.
- Emergency elderly patients, where possible were admitted directly to the frailty unit.
- AMU was a 56-bedded unit that admitted patients 24 hours a day. The AMU aimed to assess and transfer or discharge patients within 24-48 hours. When the AMU could not discharge patients home, they transferred them to a medical inpatient ward. Staff told us that length of stay could occasionally reach 4-5 days.
- Staff on the AMU had electronic boards that showed the bed state across the hospital. This helped identify when and where beds became available for patient transfer.

Medical care (including older people's care)

- There were two consultant ward rounds during the day and the consultant allocated patients to the most appropriate ward where there was a bed available.
- The AMU was adjacent to a recently opened medical assessment centre (MAC) where patients with medical conditions could be assessed, undergo investigations or receive treatment without needing to be admitted. There were plans to extend the MAC and provision of ambulatory care in two further stages. The nurses in the MAC worked closely with the AMU coordinator when a patient needed admission.
- Handover of patients from the AMU to the wards used a situation, background; assessment and recommendations approach (SBAR).
- Routine / elective medical patients and outpatients were admitted directly to the relevant base ward.
- Staff from the frailty unit and the dementia ward proactively discussed patients with staff on the admissions and short stay units to identify suitable patients to transfer to their area. This facilitated the transfer of frail and vulnerable patients to the most appropriate ward.
- The Cath lab provided angiography and percutaneous interventions for patients from a number of other hospitals in the Yorkshire region on a treat and return basis. Patient flow was reviewed every three months and the cardiology night practitioner visited wards to ensure booked patients had been prepared appropriately to prevent cancellations and delays on the day of their procedure. The unit treated booked and emergency patients between 7.30 am and 6pm and staff covered emergency procedures outside of these hours on an on call basis.
- A front door response team facilitated rapid discharge from AMU. This service was available seven days a week and feedback from hospital staff was very positive. Staff recognised that it was difficult to get social workers to attend discharge planning meetings, however there were links in place to communicate with social work teams when necessary regarding care packages.
- Wards had access to a transfer of care nurse to facilitate timely discharge and the discharge team covered weekends.
- For delayed transfers of care between April 13 and May 15, 52% of delays were due to Waiting Further NHS Non-Acute Care and 32% were due to Completion of Assessment. These reasons correspond to the top two reasons seen nationally however the percentages seen nationally were 21% and 19%.
- Delayed transfer of care was particularly a problem for patients and staff on Brearley 7, the dementia unit. Access to social workers was an issue meaning that patients could wait a long time for assessment. Other problems included funding approval for complex patients requiring placement in behavioural units or elderly mentally ill (EMI) nursing homes.
- There had been a recent incident where a patient was to be transferred to a nursing home and just prior to transfer, the home decided they could not accommodate the patient's needs fully. This meant a new placement needed to be found and this resulted in further delay.
- Staff told us that patients could be medically fit for a long-time before discharge happened. On occasions, this could be due to waiting for an IMCA to be involved in decisions about a patients care. Staff told us they had waited up to two weeks for an IMCA.
- Staff told us there were systems in place to escalate delayed discharge through hospital managers to social care managers and that the situation had improved somewhat over the last 12-18 months.
- The frailty unit had good links with the single point of access (SPA) community team who restarted packages of care for discharge and the front door response team who helped facilitate rapid discharge. Both of these service supported weekend discharges.
- An active recovery team worked in the community to assess patients at home and to initiate community therapy or nursing services and packages of care to enable patients to be cared for in their own home.
- The cardiology service had introduced an ambulatory service for heart failure patients, which staff reported, had saved many patients needing an overnight stay.
- The trust consistently exceeded the standard for referral to treatment times and was above the England average.
- Referral to treatment times (RTT) for five of the seven speciality groupings were above the 90% standard for the 18-week wait. Cardiology and dermatology were the services not achieving this standard, 72% of cardiology patients and 84% of dermatology patients received treatment within 18 weeks.
- Bed occupancy levels have consistently been lower than the England average and fluctuated between 76% and

83% whilst following the national trend. The England average had fluctuated between 86% and 91%. A trust audit of the number of beds in May 2015 found significant data quality issues with the bed occupancy data that has been provided to Department of Health. This was compounded by the migration to a new patient administration system. The trust was taking urgent action to address this issue but had concerns about the quality of this data.

- We saw that Hadfield 5 had a dedicated bay of outliers from another speciality. Staff reported there were no issues caring for these patients or with medical staff reviewing them.
- Staff on Hadfield 1 told us that they only boarded out patients who were ready for discharge and had been reviewed by their own consultant.
- We saw that some geriatric and stroke patients were transferred to the Royal Hallamshire Hospital (RHH) as outliers and a locum consultant provided medical review of those patients until discharge. Managers told us that wards at RHH and receiving medical staff were made aware of patient transfers in advance of transfers taking place. Action cards were used to ensure patients met clinical criteria before transfer to ensure the patient was safe to be moved. Only general medical and elderly patients were transferred to RHH to ensure appropriately trained doctors were readily available to provide ongoing treatment and assessment for discharge. Managers told us that patients were always clerked and had medications prescribed before transfer.
- The total number of medical outlier patients for SHFT was 987 in August 2015. Bi-monthly figures since February 2015 indicated that this situation had improved significantly and had almost halved over this six-month period, from 1828.
- Information regarding bed moves at NGH between September 2014 and August 2015 indicated that, across the medical wards, 43% of patients were moved once during their stay, 14% were moved twice, 4% three times and 2% of patients were moved 4 or more times. This equated to 684 patients being moved four or more times during their hospital stay.
- The percentage of inpatients that have had to make two or more ward moves has increased from 12% between September 2013 and August 2014 to 20% between September 2014 and August 2015.
- Patients commented that sometimes people moved wards during the night to free up a bed for someone else. Trust data indicated that in one month an average of 500 patients were moved after 10pm at night. This figure excludes those patients who were moved from the medical assessment unit and accounted for around another 400 patients a month. This equated to around 18% of patients moved, being moved late at night.
- Staff in the discharge lounge told us that patients must have their transport arranged before leaving the ward and medications with them or in pharmacy before they come, to prevent lengthy waits in this area. They told us that their standard was that patients would not be in this area for longer than four hours.
- We observed one patient leaving the discharge lounge; he had been there for one hour and 40 minutes when he left the department. The patient told us an ambulance had arrived earlier but his equipment had not arrived at home so he had needed to wait until his family could confirm this had arrived before the nurses would let him go.

Meeting people's individual needs

- STH provided an interpreting service to support the communication needs of people who are non-English speakers, people for whom English is a second language and people who are deaf. Language Line was contracted to provide telephone, face to face and British Sign Language interpreting. Bookings for face to face interpreters were made through a central team within the Trust
- We saw the telephone system in use where staff used a spider phone so they were on line at the same time as the patient and translator. This worked very effectively.
- All leaflets included a standard paragraph promoting the availability of other languages / formats on request and posters promoting communication support were displayed across the trust. There was some translated material available on the trust website.
- We saw a wide range of information leaflets were available to patients on all of the wards.
- Hadfield 1 had extended visiting times to 11am to 8pm with protected mealtimes for patients.
- We observed that buzzers were within reach of patients and nurses responded to buzzers quickly. Patients told us that nurses answered buzzers quickly.
- Staff gave us examples of where they had made adjustments for patients with a learning disability, or other cognitive impairment, when receiving care. Patients were offered a single room when possible so

carers could stay with them. Extra time was spent with patients and families to reassure and explain what was happening. Staff used topical anaesthetics when taking blood to reduce the distress and any pain experienced during this procedure.
- Wards had an identified link nurse and staff reported that they had received dementia training and awareness.
- Hadfield 5 had books and puzzles to use to provide distraction for patients when needed. 'This is me' booklets were also in use in this area and relatives were asked to complete this for patients with dementia so staff knew what patients liked or did not like. Communication tools such as picture cards were available for use with stroke patients who had difficulty communicating and hearing loops were available for patients who had hearing loss. 'This is me', booklets were also used for all patients on the dementia unit.
- Staff had an understanding that patients may have different needs and expectations due to religious or cultural beliefs and they would accommodate these needs.
- We observed a mixed sex bay on Chesterman 1, which was for level two patients.
- We saw that a female patient who needed diuretic therapy was able to arrange attendance on Chesterman 2 during school times so she could be finished in time to collect children from school.
- Patients on Brearley 7 told us there was a dining room where they could eat with other patients if they wanted to but did not feel under pressure to do this if they did not want to.
- The environment in the discharge lounge was furnished with comfortable chairs, footrests, small tables for drinks and a TV for patients' entertainment.

Learning from complaints and concerns

- Staff were encouraged to deal with patients and families concerns as they arose and many issues were dealt with without escalation to formal processes.
- Patients told us they did not know how to make a formal complaint but they would be happy to speak to the nurse in charge and were confident any issues they had would be sorted out.
- We looked at a small number of complaints investigations and found they had been thorough. Staff had met with the families concerns and had been responsive to the issues raised.
- 'Tell us what you think' leaflets were available across the medical wards. These told, patients and families how they could provide feedback, positive or negative, and advised on how to make a complaint.
- We saw information regarding making a complaint displayed on the information posters at the entrance to wards.
- Staff told us that concerns were resolved informally whenever possible and few needed to be escalated to formal processes.
- Senior managers led investigations for their area. This was a consultant for medical issues, matron for nursing issues or department head for department-specific issues.

Are medical care services well-led?

Good

We rated well-led as good because:

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

Vision and strategy for this service

- There was a strategic business plan in place for all medical services.
- We saw that the trust PROUD (Patient first, Respectful, Ownership, Unity and Deliver) values were on display throughout the wards and hospital and staff talked about what this meant to them.

Medical care (including older people's care)

- There was a clear vision for the provision of acute medical services including the development of the AMU, medical assessment clinic, ambulatory care and the frailty unit for elderly emergency admissions. There was a three-stage plan in place, led by the service development team to implement the planned changes.
- Many areas such as cardiology had a vision for their service, which was to develop, improve and expand. There were plans to develop ambulatory services for heart failure patients and to make male and female ambulatory rooms.
- Managers, clinicians and ward staff told us of the stroke services improvement plan, the changes and improvements already made and what further changes were planned. The vision for the service was to become a regional centre for stroke patients.
- Strategies for services included research aspirations and opportunities.

Governance, risk management and quality measurement

- Trust wide and service wide risk registers were in place and were regularly reviewed and updated.
- Ward managers and matrons were aware of the risks in their areas and knew how to escalate risks through the organisation if needed.
- Ward managers were aware of key issues on their wards and worked with operational and quality matrons to improve the services they delivered through regular cycles of audit, monitoring of quality indicators and improvement actions.
- Matrons and ward managers told us they carried out general and control of substances hazardous to health (COSHH) risk assessments in their own areas.
- Ward mangers told us there were governance meetings every six months where incidents and safeguarding alerts and investigations were discussed.
- Managers were clear about the risks their departments or services faced. Minutes of governance meetings clearly demonstrated discussion, escalation and actions taken.
- Staff told us that safer use of insulin had been on the risk register since 2008 but that this was appropriate, as insulin errors and omissions remained an area where incidents occasionally occurred and these could result in patient harm.

Leadership of service

- At ward level there was clear leadership of the services. Ward mangers told us they had two office days a week to undertake their management and leadership roles.
- Some ward managers held a weekly collaborative meeting with all members of the ward team including medical staff to discuss current issues and improve services. One outcome of these meetings was to introduce laminated sheets to make navigation of patient notes and finding information easier.
- Matrons gave good support to the ward managers regarding day-to-day operations as well as monitoring performance against nurse sensitive indicators.
- The manager of the hospital at night team had recently introduced self-rostering for the support workers and had delegated greater responsibility for managing their own workload using the electronic task board. The support workers and the night coordinator told us this was working well.
- Ward managers told us that there was ongoing monitoring and work to look at reasons for staff sickness to help improve sickness rates. Regular meetings had been introduced where managers looked at sickness levels, this had made it easier to escalate raised sickness levels and the impact this had on staffing wards.
- Staff told us they felt supported and knew who to escalate problems to if they could not solve something themselves.
- A member of the domestic staff told us they felt valued and had received a long service award.
- Staff and volunteers told us they enjoyed working for the trust and support staff such as porters and domestics told us they felt part of the team.
- Staff told us they were well informed if any changes were happening in their area.
- There was a senior sisters' development programme for ward managers and staff were supported to undertake other leadership programmes and courses.
- There were clear lines of accountability from the service leaders to the frontline staff.
- Staff spoke highly of clinical leadership and the clear direction they provided for service developments.

Culture within the service

- Staff told us they felt proud to work for the trust and they would be happy for their friends or family to receive care there. They told us they were well supported by their managers and there was good teamwork and support in all areas we visited.

Medical care (including older people's care)

- Sickness absence rates have followed the national trend; however, peaks have been slightly higher than the peaks in the England average (January 2011 to January 2015).
- Staff gave positive feedback regarding the culture of the organisation and as a good place to work. They felt the culture was one of improvement and staff were encouraged to report incidents and learn from them.
- Staff felt confident to raise any concerns they had about patient safety, that managers would listen and would take appropriate action.
- The service leaders and managers encouraged learning and development and supported staff through career development. Support workers wishing to gain experience and then move on to professional training were encouraged and there were sponsorship opportunities for RN training.

Public engagement

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

Staff engagement

- Staff talked about 'listening into action' and 'pass it on' events to engage staff and share learning and ideas for improvement.
- As a result of a 'listening into action' event and issues with discharge medications, junior doctors had recently become ward based to ensure there was clear responsibility for this and other tasks.
- Staff were rewarded for good practice and innovation.
- Staff told us they would recommend the trust as a place to work.

Innovation, improvement and sustainability

- We saw there had been recent development of a new acute medical unit and medical assessment centre in stage one of a three-stage plan to improve patient access and flow. Stages two and three would include further development of ambulatory care and of the frailty unit for emergency medical admissions.
- Some of the medical wards were involved in a 'ready to go' service improvement project which was investigating discharge delays.
- The cardiology service had introduced an ambulatory service for heart failure patients and had reduced the need for patients to stay overnight.
- Staff on the dementia ward were working with Bradford University to understand how the environment affects patients living with dementia.
- Managers viewed recent changes to the care groups positively and felt that these were designed to facilitate improved pathways of care for patients. For example, geriatric medicine had historically been part of acute medicine but was now combined with community services. It was hoped this would help improve integrated pathways for elderly patients between acute and community services and facilitate provision of services in the community to enable elderly patients to be cared for at home whenever possible.
- The front door response team and 'discharge to assess' were initiatives put in place to facilitate rapid discharge and ensure vulnerable patients were assessed in their own home within 24 hours.
- Advanced nurse practitioners were being developed in many areas to support clinical assessment, delivery of patient care and provide opportunities for career advancement..

Surgery

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

Information about the service

Nine clinical directorates across five care groups managed surgical services at the Northern General Hospital (NGH).

The hospital provided emergency inpatient surgical treatment, elective (planned) inpatient surgical treatment and day surgery across a range of specialities; ophthalmology, orthopaedics, cardiac, renal, vascular, burns and plastics and general surgery. There were 24 operating theatres at NGH.

Between January and December 2014 there were 31,100 surgical episodes of care carried out at NGH. Emergency cases accounted for 39% of all episodes, day cases 37% and elective cases 24%.

During this inspection we visited the following surgical wards; Chesterman 3 (thoracic), Chesterman 4 (cardiac), Firth 2 (vascular), Firth 3 and Firth 4 (colorectal) Firth 8 (upper gastrointestinal), Firth 9 (hepatobiliary and pancreatic), surgical assessment centre, Huntsman 3 (theatre admissions unit), Huntsman 4, 6, 7 and Vickers 4 (trauma and orthopaedics), Bev Stokes Day Surgery Unit, the Burns Unit, the Hand Unit, the operating theatres and recovery.

We spoke with 19 patients, one relative and 80 members of staff. We observed staff deliver care and looked at 36 patient records and 31 medication charts. We observed nursing and medical handovers. We reviewed staff records and trust policies. We also reviewed performance information from, and about, the trust. We received comments from patients and members of the public who attended our listening event and from other people who contacted us directly to tell us about their experiences.

Surgery

Summary of findings

Directorates had clear strategies driven by quality and safety aligned to the trust's vision and values. Systems and processes for infection control, medicines management and patient records were mostly reliable and appropriate to keep patients safe. Staffing levels and skill mix were planned and reviewed to keep people safe. Staff recognised and responded promptly and appropriately to risks and deteriorating patients, including overnight and at weekends. There was limited evidence of learning from incidents across directorates at ward level.

Care and treatment was planned and delivered in line with evidence based guidance and best practice. Since July 2013, the trust's RTT performance had generally been below the trust's 90% standard. However, the trust overall performed better than the England average from October 2014 to May 2015.

Staff treated patients with dignity and respect and maintained their privacy.

Are surgery services safe?

Good

The safety of this service was good. We found;

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

However we found;

- There was limited evidence of learning from incidents across directorates at ward level.
- Senior ward staff's attendance at directorate clinical governance meetings was inconsistent.
- None of the clinical staff we spoke to on the wards were familiar with the term "safety huddles" or the planned introduction of safety huddle meetings.

Incidents

- The trust had reported four never events in surgery in the 12 months prior to inspection. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Two of these occurred in theatre at NGH and were both retained throat swabs. Staff had put new procedures in place: moved throat swabs to a different location and changed the way they recorded the swab count on the white board and in the theatre record. We saw evidence that these changes were in place during our inspection and staff we spoke to were all able to explain the changes to their practice that had taken place as a result of the never events.
- All staff in theatre had a clear understanding of the two never events in theatre at Weston Park Hospital (wrong lens insertion in cataract surgery) and were able to explain the change in practice that had occurred in ophthalmic surgery.

Surgery

- The trust had reported 10 serious incidents between August 2014 and July 2015, seven of these happened at NGH. We reviewed investigations that all contained recommendations and action plans. We saw evidence during our inspection of changes made to practice as a result of the incidents.
- Nine hundred and thirty nine incidents had been reported in the service between November 2014 and October 2015, 73% of these were graded as no harm and 27% minor harm or damage. Themes of the incidents included falls, pressure ulcers and medication incidents.
- Staff reported incidents on an electronic system. Staff we spoke to were aware of how to report an incident, and gave examples of changes that had happened following incidents. For example, a patient in the Hand Unit who was delayed going to theatre, was subsequently found to have a low temperature in theatre. Staff now regularly checked patient's temperatures if they were delayed going to theatre and provided blankets. Staff in the Surgical Assessment Centre also explained that as a result of feedback from incidents reported as falls, they now used the falls risk assessment they completed on admission to determine in which area of the ward to nurse patients.
- Senior ward staff investigated incidents with support from the directorate governance lead. The tissue viability team completed root cause analysis on pressure ulcers and the infection prevention and control team completed root cause analysis on incidences of Methicillin Resistant Staphylococcus aureus (MRSA) and Clostridium difficile (c. difficile).
- Most staff we spoke to reported receiving feedback about incidents from ward managers and through team meetings. We saw evidence of weekly half hour huddle newsletters in theatre, where safety performance information and lessons learnt were shared. Senior staff in the Bev Stokes Day Surgery Unit had introduced a learning and improving from incidents file that shared information with staff and encouraged reflection.
- There was limited evidence of learning from incidents in other directorates at ward level. Staff in the Hospital at Night team reported incidents across a number of directorates, but were unable to tell us themes of incidents in the trust or directorates. Senior ward staff were invited to attend the directorate clinical governance meeting and did when time allowed. We reviewed minutes from 11 of these meetings and found there was limited recorded discussion of learning from incidents in other directorates.
- One of the trust's key objectives linked to the improvement priorities 2015/16 was to introduce "safety huddles" (a small meeting focussed on patient safety, to ensure that patient safety is at the forefront in every clinical handover). None of the clinical staff we spoke to on the wards were familiar with this term or meeting.
- Staff attended morbidity and mortality meetings within the clinical directorate. We reviewed eight sets of meeting minutes from four clinical directorates over the last six months. Most directorates reviewed morbidity cases as well as mortality cases. However, where the outcome of the review affected another clinical directorate, it was not clear from the minutes whether this was communicated to the other directorate and whether actions were reviewed.
- We reviewed a copy of the fourth annual mortality and morbidity report for hepatobiliary surgery that discussed activity of the four hepatobiliary surgeons, complication rates, returns to theatre and any learning points from inquests.

Duty of Candour

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

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for local measuring, monitoring and

analysing patient harms and 'harm free' care. This focuses on four avoidable harms: pressure ulcers, falls, urinary tract infections in patients with a catheter (CUTI), and blood clots or venous thromboembolism (VTE).
- Not all wards displayed safety thermometer information in the clinical area. This meant staff, patients and relatives could not see the amount of harm free care that was provided.
- In the reporting period December 2014 to December 2015, the service reported 225 incidents of harm at NGH. One hundred and forty seven pressure ulcers, 37 falls with harm, 25 CUTIs and 16 VTE

Cleanliness, infection control and hygiene

- All wards and theatre areas were visibly clean. The toilet facilities we viewed were clean, however, the cleaning schedule was missing or inconsistently completed.
- Clinical areas displayed infection prevention and control information visible to patients and visitors.
- Information submitted by the trust showed there had been six trust attributable episodes of MRSA in the service in 2015/16 up to July 2015.
- Information submitted by the trust showed there had been three trust attributable episodes of C. difficile in the service in 2015/16 up to July 2015.
- We observed all staff were compliant with key trust infection control policies, for example, hand hygiene, personal protective equipment (PPE), and isolation.
- We reviewed the documented checks which had been completed daily, weekly and monthly checks for the anaesthetic and scrub rooms. This provided assurance that staff completed daily cleaning, flushing of water systems and monthly deep cleaning of the areas.
- Pre-operative assessment staff carried out MRSA screening on elective surgical patients.
- Staff told us rapid response cleaning was available in theatre.
- Information submitted by the trust showed 73% of staff had completed infection control training. This was lower than the trust target of 90%.
- The trust had an infection prevention accreditation programme to provide a framework for assessment and standardisation of infection prevention and control practice in clinical areas. Ward managers completed monthly and quarterly audits in line with the programme schedule and evidence was reviewed with the Infection Prevention and Control Team (IPCT). Accreditation was awarded annually when the evidence supporting achievement of the requirements was satisfactory and re-accreditation was required annually. Information provided by the trust showed that at 29 September 2015 all but three areas in the service did not have infection prevention accreditation; these were Chesterman theatres, Firth 8 and Huntsman 6. Ward managers in these areas worked closely with the ICPT to achieve the actions required.
- The infection rate for hip and knee arthroplasty was 0%. This was better than the national figure of 0.8% for hips and 0.7% for knees.

Environment and equipment

- Access to wards and theatres was secure with communications via an intercom.
- Equipment was visibly clean. Clinical areas had limited storage for equipment; on six of the wards we visited equipment was stored in bathrooms or in the corridor where it caused an obstruction.
- We observed double yellow lines had been painted on the floor in theatre corridors to discourage staff from leaving or storing equipment in the corridor.
- We reviewed documentation for anaesthetic rooms and scrub rooms. This provided assurance that staff completed equipment, stock levels and waste disposal checks.
- The trust had consistently higher scores than the England average in the Patient-led Assessments of the Care Environment (PLACE).
- Staff did not consistently complete the daily check of resuscitation equipment across the service. On three wards, records were complete and on three other wards, records were incomplete. On one of these wards, staff were unclear whether a faulty piece of resuscitation equipment (defibrillator) had been reported or repaired. This meant the equipment might not have been in working order if needed in an emergency. We discussed this with the ward manager at the time who was then going to ensure it was repaired.
- We checked sixteen pieces of equipment, for example blood pressure monitors and hoists, on three wards; eight of them been appropriately tested and were within their service date.
- Patients had access to day rooms on the wards; these varied in design. The day rooms on the Firth wards were spacious, had sofas, televisions, dining tables, and

chairs available to patients. The day room on Chesterman 4 was untidy, had only waiting room style chairs and was used for inpatients and as a waiting area for theatre admissions.
- Patients had access to good facilities in the Hand Unit with lockers being available for valuables. Staff had said that curtains were not appropriate for privacy and dignity so new changing rooms had been built.

Medicines

- The service had appropriate systems to ensure that medicines were handled safely and stored securely. Controlled drugs were appropriately stored with access restricted to authorised staff. Staff kept accurate records and performed daily balance checks in line with the trust policy.
- Staff did not always monitor medication fridge temperatures in line with trust policy and national guidance. We saw evidence of this on Chesterman 3, Surgical Assessment Centre and Firth 2. This meant that medications might not have been stored appropriately.
- We reviewed 31 drug prescription and administration records 23 of which were complete. Two were not legible, signed or dated consistently, two did not have antibiotics prescribed in line with trust guidance and four did not have written reasons for missed or omitted medications.
- Oxygen was not prescribed in line with trust policy on two of the MARs we reviewed.
- Chesterman 3 did not have a clinical pharmacist service. Staff thought this led to delays in obtaining medicines, including discharge prescriptions.
- Of the drug prescription and administration records we reviewed, one patient on Surgical Assessment Centre was managing their own medication. Staff had not assessed or documented the patient's ability to self-medicate which was not in line with trust policy on self-administration of medication.
- Intravenous fluids were not always stored safely and securely. Store room doors on Chesterman 3, Surgical Assessment Centre and Chesterman 4 did not have all have locks on or were left open. This meant that that access to fluids was not restricted to authorised staff. This had been raised as a trust wide issue at the medicine safety committee and was on the trust risk register. We checked medicines for emergency use and found that they were readily available, stored appropriately, and that regular checks had been performed to ensure that they were fit for use in line with trust policy.
- The service completed quarterly antibiotic prescribing bundle audits. Results ranged from 18% to 100% compliance. The main omissions were a lack of stop or review date on the drug prescription and administration record and a lack of indication for treatment written in the patient record. Information provided by the trust did not include an action plan for the audits.
- The trust completed a quarterly drug related incident report. Results were trustwide and not broken down into core service.
- NICE guidance recommends in an acute setting medicines reconciliation is carried out within 24hrs. The trust monitored medicines reconciliation over a 24hr period each month. The trust submitted information that showed 80% of medicines reconciliation was completed, although less than 60% occurred within 24 hours.

Records

- Records were not always stored securely. On two of the wards we visited, staff had left patient records out on the nurses' station. We found loose sheets in the record, which meant that notes may not always be contemporaneous, and there was a risk that part of the record could be lost.
- On two of the wards we visited, members of staff had left their identity card unattended in the computer for over 10 minutes. This meant that unauthorised staff could access patients' confidential information.
- We reviewed 35 sets of records. Overall, the content of 90% of them was accurate, complete and in line with professional Nursing and Midwifery Council standards. None of the records we reviewed met General Medical Council guidance on keeping records as medical staff did not record their GMC number. Other omissions were that staff did not print their name and grade after an entry or that the care plan did not contain all the patient's individual needs.
- Following the introduction of an electronic patient record, slim notes had been developed in pre-operative assessment. Staff told us the slim notes did not contain sufficient information as the record only started at the pre-assessment stage and did not contain the original referral letter or any outpatient notes.

- The trust completed hospital wide documentation audits to assess the quality and standard of the completion of records. We did not review the results of these audits in the service.
- Information governance training was included as part of the mandatory training programme. Information submitted by the trust showed 82% of staff had completed this training. This was lower than the trust target of 90%.

Safeguarding

- All staff we spoke to were clear about what may be seen as a safeguarding issue and how to escalate safeguarding concerns.
- Staff we spoke to knew how to access the trust's safeguarding policy and the safeguarding lead.
- Wards and theatre had safeguarding link nurses.
- We saw evidence of geriatricians' attendance on orthopaedic and other surgical wards including clear management plans documented in the patient record.
- Information submitted by the trust showed 90% of staff had completed safeguarding adults level one training. This was in line with the trust target of 90%. Seventy seven percent of staff had completed safeguarding adults level two training. This was below the trust target of 90%.
- Information submitted by the trust showed 88% of staff had completed safeguarding children level one training. This was below the trust target of 90%.

Mandatory training

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

Assessing and responding to patient risk

- The trust used a local adaptation of a national early warning tool called Sheffield Early Warning Score (SHEWS) that indicated when a patient's condition may be deteriorating.
- The trust had a pathway for the deteriorating patient. Clinical areas we visited displayed the pathway at the nurses' station which included staff contact details.
- The records we reviewed had completed SHEWS scores and appropriate responses documented. Staff put an orange sticker in the patient record to easily identify a deteriorating patient's management plan.
- Nurses told us there was no delay in surgical staff reviewing surgical patients; we observed doctors on the ward responding promptly to their bleeps.
- Advanced nurse practitioners (ANP's) and doctors provided medical cover overnight as the Hospital at Night team. All staff told us the Hospital at Night team responded to bleeps and reviewed patients promptly. One ANP was a coordinator in the team overnight. They acted as a central point of contact for ward staff, prioritised and delegated work to the team and made sure staff actioned the work. One of the roles of the coordinator and team was to ensure the right person attended the patient at the right time.
- Most of the surgical wards had medical patients (outliers). Staff on five wards told us there was no set procedure for medical staff to review these patients. Nurses looked at the patient record and contacted the last doctor that had reviewed the patient. This meant staff may not have been contacting the patient's own medical team if the last doctor to review them had been working out of hours.
- Staff completed risk assessments on patients. These risk assessments included moving and handling, falls, nutrition, tissue viability and VTE. In the 36 records we reviewed, 21 of the risk assessments were incomplete. Where the assessment had been completed and risks were noted, staff had completed appropriate care plans.
- Wards provided ultra-low beds for patient at high risk of falls and non-slip socks for patients without their own slippers. Staff explained the areas on the ward used to nurse patients at high risk of falls. These were usually areas observable from a nurse's station.
- Chesterman 3 was one of the places of safety in the trust for patients with a tracheostomy (an opening made through the neck into the trachea (windpipe) through which a patient can breathe) or laryngectomy (removal

of the voice box to enable the patient to breathe). A place of safety in the trust was where staff had training and were competent to care for specific needs of patients.

- The World Health Organisation (WHO) surgical safety checklist is a core set of safety checks, identified for improving performance at safety critical time points within the patient's intraoperative care pathway. We observed the checklist being used appropriately in theatre and saw completed preoperative checklists and consent documentation in the patient record.
- Audit data on the WHO surgical safety checklist provided by the trust prior to the inspection was for 2013/14. We saw evidence during the inspection of spot check audits that took place. Twenty eight spot check audits had been completed across the trust up to 30 November 2015; 15 at NGH. Compliance was between 61% and 100% with the lowest compliance being the planned start and end times being discussed and issues raised and escalated appropriately at debrief.
- Patients that underwent day surgery received care in line with best practice guidance from the Association of Anaesthetists of Great Britain and Ireland and the British Association of Day Surgery Guidance 2011. Staff gave patients an information leaflet which contained 24 hours contact numbers and telephoned patients who had a general anaesthetic the following day. We observed records that contained a copy of the patient's operation note, staff in the day surgery unit documented discussions they had with patients on the operation note.

Nursing staffing

- The trust used three tools to determine appropriate levels of staffing; the safer nursing care tool, professional judgement and nursing hours per patient day. The trust target was for there to be an average ratio of 70/30 registered nurses to clinical support workers across all inpatient areas. The chief nurse prepared a monthly staffing report for the board and highlighted areas that had a variance of greater than 15% against either day or night staffing for nurses or support workers.
- Wards displayed the planned and actual staffing figures. During our inspection the actual number of staff on duty was lower than the planned number of staff on most of the wards we visited. Senior staff told us they assessed the staffing situation across the trust, and made a clinical decision about re-deployment of staffing resources.
- Information submitted by the trust showed clinical areas in the service had 50 whole-time equivalent (WTE) nursing vacancies from their established level. Recruitment was ongoing.
- Sickness in the service was 6.3% against a trust target of 4%.
- We reviewed the monthly staffing report for October 2015; two wards in the service had a variance of greater than 15% for registered nurses; Huntsman 4 and Huntsman 6. Huntsman 3 had the highest use of bank staff with an average of 18%.
- The trust did not collect staffing data in isolation and took account of quality aspects of patient care using national Nurse Sensitive Indicators (NSIs). These were infection rates (hospital acquired MRSA infection and colonisations and C.difficile rates); formal complaints related to nursing care, falls, medication errors and pressure sore rates. The trust submitted evidence that NSI's were recorded and reported. This shows that care groups monitored quality indicators that may cause patient harm.
- The total NSI's for the year showed that discharge incidents were highest on Vickers 4 and Huntsman 6, complaints highest on Surgical Assessment Centre and Firth 8 and falls were highest on Vickers 4.
- Staffing in orthopaedics was on the risk register; Huntsman 6 and 7 regularly used agency staff to cover vacancies. Senior staff completed a block agency booking to improve continuity and we were shown evidence of the local induction agency staff completed. The average bank staff usage on Huntsman 6 was 8.1% and 10% on Huntsman 7.
- The trust opened Huntsman 3 to care for inpatients overnight, as well as theatre admission patients in the day, when additional bed capacity was required in surgery. Staff called this the surge ward. Staff moved from other wards in the trust, bank and agency staff worked on the ward. We saw evidence that bank and agency staff completed a local induction, mandatory training and had access to trust computer systems.
- All registered nurses and clinical support workers we spoke to reported they were unhappy that they were

moved to cover other wards across hospital sites regularly and at short notice. Staff recognised the need to keep patients safe, however it was clear this had an impact on staff morale.
- We observed an evening handover on three wards. On two wards, the handover was late starting as staff were busy delivering care to patients. On these two wards the handover took place on the ward, nurses were interrupted by enquiries from other staff and telephone calls. The handover took place before the end of visiting time and visitors were present on the ward. This meant that visitors may have overhead information about patients.

Surgical staffing

- Consultant medical staff were accessible 24 hours a day, seven days a week. Senior medical staff reviewed patients daily.
- Information submitted by the trust showed that the only medical and dental vacancies in the service were in the musculoskeletal care group at 5.9 WTE.
- Within surgery, similar rates of medical staffing to the England average levels were noted: Consultant staffing at 45% trust level versus 41% England average, registrar grade medical staff at 38% versus 37% England average and junior medical staff 13% versus England average of 12%. However, from data up to September 2014, there was a lower number of middle grade staff at 3% compared to the 11% England average.
- Surgical cover at NGH encompassed a significant range of specialties. During daytime hours Monday to Friday, each speciality managed its own team of doctors.
- The Hospital at Night team consisted of a multidisciplinary team of Advanced Nurse Practitioners (ANPs) and junior doctors that had the competence to cover a wide range of interventions and with the capacity to call in specialist expertise when necessary.
- The Hospital at Night team had dedicated morning and evening handover. We observed an evening handover where staff discussed all admissions and acute patients, reviewed results of investigations and agreed management plans.

Major incident awareness and training

- Senior staff clearly explained their major incident and business continuity plans. The actions described were in line with the trust's major incident plan.
- Staff knew how to access the major incident and continuity plans on the intranet and explained the steps they would take to seek instruction from senior staff.
- An Operating Department Practitioner had recently participated in medical emergency response incident training (MERIT).

Are surgery services effective?

Good

The effectiveness of this service was good. We found;

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

Evidence-based care and treatment

- Staff were aware of relevant policies and guidelines and showed us how they would access them on the trust intranet.
- Policies and guidelines were based on relevant and current evidence base and best practice from appropriate professional bodies, including National Institute of Health and Clinical Excellence (NICE), Royal College of Surgeons (RCS), Association of Anaesthetists of Great Britain and Ireland (AAGBI) and the British Association of Day Surgery Guidance.
- Pre-operative assessment was in line with NICE CG3 (pre-operative tests). Pre-operative practitioners completed an assessment in line with national guidance. They had immediate access to an anaesthetist.
- Staff followed the enhanced recovery programme (NHS Institute for Innovation and Improvement) in many

specialities. We saw evidence on Chesterman 3 and 4 that this practice was embedded. An information display on Firth 4 showed how the programme had reduced patients' length of stay.
- Surgical pathways were in line with NICE CG92 (venous thromboembolism: reducing the risk for patients in hospital).
- We reviewed the tracheostomy and laryngectomy resource file on Chesterman 3. The policies and documents were based on the national tracheostomy project guidance.

Pain relief

- As part of the SHEWS observation chart and intentional rounding (a structured approach whereby nurses conduct checks on patients at set times to assess and manage their fundamental care needs), staff regularly asked patients about their pain levels and recorded the scores.
- All the wards in the service scored good (75% or above) in the question "staff definitely doing everything they can to help control patients' pain" on the frequent feedback inpatient survey from April 2014 to March 2015.
- Staff had access to an acute pain team. The acute pain team routinely reviewed patients with an epidural or patient controlled analgesia (types of continuous pain relief used post-operatively) and other patients on request.
- We reviewed 36 patient records and observed staff assessing pain and giving support to patients requiring pain relief.
- Eight patients that we asked about their pain relief told us that their pain was managed effectively and kept under control.
- Patient information included a section how to manage pain symptoms following discharge from hospital.

Nutrition and hydration

- Staff screened patients on admission using the Malnutrition Universal Screening Tool (MUST). If the assessment triggered a risk or concern staff completed a referral to the dietician.
- The MUST assessment was complete in 28 of the 36 records we reviewed.
- The trust had introduced HANAT (hydration and nutrition assurance toolkit) to encourage good nutrition and hydration best practice in the hospital environment. Staff on Huntsman 7 demonstrated a good understanding of the tool.
- Nutrition clinical nurse specialists, pharmacists and dieticians participated in a nutritional ward rounds.
- Staff told us they contacted a catering manager and the dietician to accommodate patients' allergies, religious beliefs and preferences with meals.
- The patient flow coordinator in theatre informed staff on Huntsman 3 of delays or changes to operating lists due to emergency and trauma cases. Staff used this information to try and ensure that patients were not fasted for longer than was necessary.
- Wards used protected meal times. We saw staff supported patients with menu choices and assisted with feeding if required. Patients told us staff offered food and water regularly. We observed patients had water and drinks within reach.
- All the wards in the service scored 63% or above in the question "patients always receiving the help they need to eat or drink" on the frequent feedback inpatient survey from April 2014 to March 2015.

Patient outcomes

- The hospital had higher than the England average standardised relative readmission rates (2014) for elective surgical patients for trauma and orthopaedics, colorectal and hepatobiliary and pancreatic surgery.
- The hospital had higher than the England average standardised relative readmission rates (2014) for non-elective surgical patients for trauma and orthopaedics, colorectal and general surgery.
- The National Bowel Cancer Audit (2014) showed mixed results. The trust scored better than England average for multi-disciplinary team discussion, clinical nurse specialist involvement and scans undertaken. However, the trust attempted laparoscopic surgery in 35.7% of patients (lower than the England average of 54.8%) and 76.8.8 % of patients undergoing major surgery stayed in the trust for an average of more than five days (worse than the England average of 69.1%).
- The Lung Cancer Audit (2014) results showed the percentage of patients receiving surgery was similar to

the England average. The audit showed better results than the England average for multi-disciplinary team discussion and for scans undertaken before bronchoscopy.

- The trust participated in the National Hip Fracture Audit. Findings from the 2014 report showed the hospital was better than the national average in five out of seven areas. Examples were patients admitted to an orthopaedic ward within four hours, surgery on the day of or the day after admission and preoperative assessment by a geriatrician. The hospital was worse than the national average in patients developing pressure ulcers and the total length of stay. The trust had set up a multi professional fractured neck of femur group to review length of stay and mortality.
- We found the National Emergency Laparotomy Organisational Audit 2014 showed 13 out of 28 measures (46%) were not available. For the 2015 patient audit results, the trust scored green (70-100%) for the standard "arrival in theatre in timescale appropriate to urgency". The trust scored amber/red (below 69%) for the other 10 standards, which included "preoperative review by consultant surgeon and anaesthetist" and "consultant surgeon and anaesthetist present in theatre." The trust submitted the report to the clinical effectiveness committee following the audit. An action plan was developed that included relaunching the pathway for emergency laparotomy patients across the trust and reviewing the daily input from elderly medicine.
- The trust underwent an Anaesthesia Clinical Services Accreditation review in 2015. This review assessed performance against 95 standards. The review concluded satisfactory evidence had been supplied to meet 89 of the standards. We saw evidence that the trust was working towards the recommendations of the review to meet the remaining six standards. The unmet standards included administration support, trust support for audit and research and evidence of training in the use of equipment. The trust was subsequently awarded accreditation.
- The National Joint Registry (NJR) summary data for 2015 showed the consent rate from patients to have their details entered into the NJR was 85%, below the national average of 93%.
- The trust's overall performance record for Patient Reported Outcomes Measures (PROMs) for hip and knee replacements and varicose vein surgery is in line with the national average. A PROM for groin hernia procedures (EQ-5D Index) had seen smaller improvements and worse results than the national average.
- Overall, the trust completed 52% of procedures as day cases. NGH had a day case rate of 37%.
- The trust participated in Hip Attack, which was an international research trial of patients with a hip fracture that required surgical intervention.
- Staff in the Bev Stokes Day Surgery Unit completed an audit on spinal anaesthesia used for a specific procedure. This resulted in a change in practice by the anaesthetists and improved patient outcomes.
- Some clinicians told us it was difficult to access clinical outcome data. Trust databases recorded clinical activities rather than outcome data.

Competent staff

- All medical and nursing staff we spoke to told us they had undergone an appraisal within the last 12 months. Information submitted by the trust showed between 72% and 100% of staff had completed their appraisal. The trust target was 95%.
- We reviewed theatre staff's equipment log. This was a record of their medical device training. These were completed and up to date.
- New members of nursing staff had up to a four week supernumerary period with an allocated mentor.
- New and supernumerary staff in cardiac theatre wore a different coloured hat so staff could identify they were new or working under supervision.
- Clinical educators worked in clinical directorates and facilitated teaching sessions and training.
- A new clinical educator was in post in cardiac theatres; we saw evidence of competencies and induction packs that trust and agency staff working in cardiac theatres completed.
- Staff told us the trust supported their training and development. For example, ANP's in Hospital at Night completed an MSc in advanced practice, clinical support workers on Huntsman 3 completed competencies to look after a patient following a local anaesthetic and staff in Surgical Assessment Centre completed BSc and MSc degrees.
- During our inspection, we observed staff teaching junior staff on ward rounds.

- Every four to six weeks the Hand Unit started a theatre list late to give an opportunity to provide teaching to the multidisciplinary team.
- Wards and theatres provided placements for student nurses. Theatres also provided placements for trainee ODPs. All the students we spoke to described the staff as supportive and the areas as a good learning environment.
- Senior staff were confident to manage performance issues in line with the trust policy and with support from human resources.
- Clinical and non-clinical staff told us the training they received for the electronic patient record was not specific to their role.

Multidisciplinary working

- Staff told us there was good teamwork and communication within the multidisciplinary team. We observed this during our inspection.
- There was effective daily communication between the ward and theatres this ensured patients were being transferred to and from theatre efficiently. We observed staff informing patients of their plan of care.
- All the records we reviewed had evidence of a multidisciplinary treatment plan.
- Clinical areas carried out daily multidisciplinary ward rounds or handovers. Most wards held a weekly multidisciplinary team meeting; surgeons, geriatricians, therapists and ward staff attended these.
- Staff told us the discharge nurse, transfer of care team, pharmacists and technicians, psychologist, geriatrician, palliative care and spinal injury teams supported them to meet their patient's needs.
- Multidisciplinary staff attended a daily trauma meeting Monday to Saturday. This acted as a handover and an opportunity to prioritise and finalise the theatre list.
- The ward manager on Firth 2 explained how the medical specialities of vascular surgery and diabetes on the ward worked together to improve patient care. They gave the example of a diabetic patient with a foot ulcer having shared care between the two medical teams.

Seven-day services

- Elective surgery took place from Monday to Friday. Cardiac theatres provided two additional elective cases on a Saturday. The minor operating theatre in the hand unit opened on bank holidays.
- Emergency theatre facilities were available 24 hours a day, seven days a week in line with National Confidential Enquiry into Patient Outcome and Death guidance. A senior nurse met with emergency staff including anaesthetists and surgeons and coordinated the activity.
- Consultants were available on-call out of hours on a rota and had scheduled ward rounds to see patients at weekends in most specialities.
- General surgical staff used a sticker to identify weekend plans in patients' notes. This helped facilitate a nurse led discharge.
- Physiotherapy, imaging services and pharmacy provision was available on an out of hour's on-call basis seven days a week.

Access to information

- Staff were able to access blood results and x-rays using electronic results services.
- Staff told us the radiology service was responsive and reported images promptly.
- GP's referred patients to Surgical Assessment Centre using a central, online system. GP's did not directly discuss referrals with a doctor unless they requested to.
- Staff completed an electronic discharge letter that included medications. The GP and patient received a copy and staff put a copy in the patient record.
- Nurses referred patients to the community nursing team through a single point of access.
- Administration and secretarial staff told us the electronic patient record did not work in line with the other electronic programmes they used. The secretarial work they had typed into one programme then had to be uploaded into the electronic patient record.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with demonstrated an understanding of consent, the Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLs).
- We observed staff obtained verbal consent from patients before carrying out an intervention.
- All the patients we spoke to told us staff explained their care and treatment to them and sought consent prior to delivering the care.
- Consent forms were complete in 33 of the 36 records we reviewed.

- The trust submitted an audit on the completion of consent forms in the Hand Unit in April and May 2015. The areas of non-compliance were the use of abbreviations, signing of the confirmation of consent form and a copy of the consent form being given to the patient. The department had introduced standardised printed labels to reduce the use of abbreviations and focussed on education of staff at induction.
- Staff told us they would speak to the nurse in charge, the transfer of care team or a member of the medical team if they had concerns regarding a patient's capacity. All staff knew how to access MCA and DoLs guidance.
- We reviewed medical clerking proformas. They included cognitive assessment

Are surgery services caring?

Good

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

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

Compassionate care

- The NHS Friends and Family Test (FFT) showed a response rate in line with the England average. Between 79% and 100% of patients would recommend the service to their family or friends.
- Prior to the inspection the trust provided results of the frequent feedback inpatient survey from April 2014 to March 2015. The survey was split into three sections; hospital environment, doctors and nurses and care and treatment Scores on the surgical wards ranged from 38% to 100%; the lowest score on every ward was the question "patients rating ward as excellent". Patients scored the majority of the rest of the questions as average or above.
- Some wards displayed the results of the trust's patient survey. On Huntsman 6 and Huntsman 7, 90% and 88% of patients felt treated them with respect and dignity. Ninety seven percent of patients on Huntsman 6 and 95% on Huntsman 7 felt they received excellent, very good or good care.
- We reviewed the patient's comments book in the Bev Stokes Day Surgery Unit; all the comments were positive about the attitude of the staff and patients' experiences.
- Staff treated patients with dignity and respect and maintained their privacy. During all interventions, staff drew curtains around patients and patients were kept covered with sheets and blankets.
- All staff communicated in a kind and compassionate way with patients.
- We observed patients' call bells were placed within reach and staff responded in a timely and respectful manner to patients' requests. However, patients commented that they thought the staff were busy.
- A patient on the Burns Unit who had never been in hospital before was overwhelmed with the quality of care they had received and thought it was better than care would be in a private hospital.

Understanding and involvement of patients and those close to them

- Wards displayed visiting times and information for patients and visitors.
- All the patients and relatives we spoke with told us staff kept them informed of their treatment and progress and that they were involved in the decisions made by all members of the multidisciplinary team.
- We saw evidence in the records where patients and their relatives had been involved in making decisions about their care and treatment.
- We observed staff involving patients in their care.
- Chesterman 4 displayed a board for patients with information from the British Heart Foundation and Sheffield Open Heart Club, a local fundraising charity that raised money for the ward.
- We observed a consultant review a patient pre-operatively on Chesterman 4. They explained the operation in words the patient could understand and drew diagrams. The consultant answered all the patient's questions including those around their social needs and discharge plan.
- Theatre staff had arranged a focus group for patients to attend and give feedback. This had not yet been held at the time of our inspection.

Surgery

Emotional support

- We observed staff interacting with patients in a supportive and reassuring manner, encouraging them to regain their independence in line with their post-operative progress.
- Clinical Nurse Specialists provided support services that patients accessed pre-operatively, during admission and after discharge. Examples were stoma care, colorectal, pain and thoracic nurse specialists.
- Staff referred patients who underwent thoracic surgery to a local specialist respiratory unit for physical and emotional pre-operative preparation.
- Staff on two wards told us there was a delay in patients receiving a psychiatry review; at times, this could delay discharge

Are surgery services responsive?

Good

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

- The needs of different people were taken into account when planning and delivering services.
- The facilities and premises were appropriate for the services being delivered.
- Since July 2013, the trust's RTT performance had generally been below the trust's 90% standard. However, the trust overall performed better than the England average since October 2014.
- Cancelled operations were lower than, or in line with, the national average.
- Complaints and concerns were dealt with in an open, transparent and timely manner

Service planning and delivery to meet the needs of local people

- The trust engaged with internal and external stakeholders, patients, governors, members, partners and staff to plan services.
- Local clinical commissioning groups and the national commissioning board commissioned services within the trust. Some specialist services were provided regionally and nationally.
- The musculoskeletal care group had developed a new contractual framework in partnership with Sheffield clinical commissioning group, which resulted in the development of a single clinical triage point that directed patients for care in the right place at the right time.
- A purpose built cataract centre was being built at the Northern General Hospital (NGH) as a long term plan to address the capacity issue.
- Chesterman 3 and Firth 2 had facilities to review recent inpatients or ward attenders on the ward. Ward staff provided continuity of care to patients.
- Staff in theatre completed audits that showed there was no private area for staff to have discussions with relatives or for relatives to wait. As a result, staff created a room within the theatre department with a seating area, tea and coffee and a screened off area with a bed. Staff told us this has been used when consultants required somewhere private to talk to relatives and when there had been distressed and grieving relatives in the department.
- The Bev Stokes Day Surgery unit focused on the patients' experience. The unit was designed so patients moved through the unit in a circular design, always moving forwards and towards discharge.
- The trust provided a bus service for patients and relatives to access across hospital sites.

Access and flow

- The target Referral to Treatment time (RTT) is set within the NHS at 18 weeks from referral from general practitioner to treatment time. Since July 2013, the trust's RTT performance had generally been below the trust's 90% standard. Data reviewed for May 2015 showed general surgery, trauma and orthopaedics and cardiothoracic surgery did not meet the standard. Thoracic medicine and plastic surgery met the standard. However, the trust overall performed better than the England average during this period.
- Senior staff told us the complexity of patients referred for regional and national treatment contributed to their not meeting RTT standards. For example, local trusts sometimes referred patients with multiple medical problems that needed treatment before they were fit enough for a major operation.

Surgery

- Twenty four theatres were available at NGH and provided emergency and elective surgery. Data submitted by the trust showed the average theatre utilisation rate was 77% between June and August 2015.
- The patient flow matron in theatre was responsible for scheduling of operations. A duty floor anaesthetist worked across the theatres every day to recognise and trouble shoot problems such as capacity, overruns and pain relief issues.
- The total number of cancelled operations treated within 28 days had decreased since July 2014. However, the amount of cancelled operations not treated within 28 days had increased. The percentage of patients whose operation was cancelled and then were not treated within 28 days had consistently been lower than the national average. Cancelled operations as a percentage of elective admissions had been lower than, or in line with, the national average since March 2013.
- The main reasons for cancelled operations was a lack of ward and critical care beds, a lack of theatre time or if a more urgent case took precedence. A member of the pre-operative assessment team routinely contacted patients four days prior to their operation date to confirm they were fit enough for surgery and planned to attend. Following the introduction of this, cancellations had been reduced to less than four percent.
- Senior staff monitored cancelled operations and completed a root cause analysis for patients that were not treated within 28 days. Clinical directorates held a weekly patient tracking list meeting.
- An extended recovery unit was available in theatre for patients who required an extended stay in recovery, but were unlikely to require admission to a high dependency unit. The Anaesthesia Clinical Services Accreditation review stated this was an innovative and practical response to bed pressures in critical care.
- The average length of stay for non-elective patients was in line with the national average. The average length of stay for elective patients was longer than the England.
- Senior staff on Huntsman 3 worked with surgeons to develop day case pathways with staggered admission times to improve the flow of patients. They reported improvements had been made to the foot and ankle theatre list.
- The minor operating theatre in the hand unit had reduced the pressure on the main theatres and reduced patient waiting times. It operated six sessions a week for elective cases and trauma cases.
- The rapid access surgical pathway clinic introduced to Surgical Assessment Centre had reduced hospital admissions.
- No patients had stayed overnight in recovery area of theatres in the last 12 months.
- There had been no mixed sex accommodation breaches in the last 12 months.
- The trust opened Huntsman 3 to care for inpatients overnight as well as theatre admission patients in the day when additional bed capacity was required in surgery. Staff called this the surge ward. Managers had opened the surge ward for four consecutive weekends prior to our inspection. The trust staffed the additional beds by moving nurses from other surgical wards or using bank and agency staff. Senior staff told us medically stable patients that were approaching discharge were moved to the surge beds. On one of the days of our inspection, 10 out of 32 patients on Huntsman 3 were “surge patients.” We reviewed the notes of the 10 patients; five of them did not have a documented discharge plan.
- Discharge planning began at the pre-assessment stage. The trust set a planned date of discharge as soon as possible after admission. Wards worked with the discharge coordinator, transfer of care team and community services to reduce delays for patients with complex needs.
- The trust provided specialist regional and national services. Staff told us repatriation of these patients was difficult because of the pressure on NHS beds nationwide.

Meeting people’s individual needs

- The trust produced standardised up to date, cross site information for patients on specific conditions or aspects of being in hospital, for example, preparing for your operation and laparoscopic anti-reflux (GORD) surgery including dietary advice following surgery.
- Pre-operative assessment staff gave information leaflets to patients to ensure they fully understood their treatment and could give valid consent. The information for patients was broken down into four phases. Staff gave it to patients at the relevant point of their journey.
- Leaflets were available in alternative languages and formats on request.
- Interpreting services were available for patients whose first language was not English. Staff explained the process of booking an interpreter to us.

Surgery

- The service was responsive to the needs of patients living with dementia and learning disabilities. Link nurses who provided advice and support with caring for patients with learning disabilities and dementia had been identified in all areas including theatre.
- Staff showed us communication aids they used with patients living with dementia and learning disabilities and activities they completed with them.
- Staff in the Bev Stokes Day Surgery Unit told us there was good communication with pre-assessment staff to ensure vulnerable patients got the best possible care. They gave an example of how they re-arranged a date for surgery and ensured staff were on duty that the patient had already developed a rapport with.
- Staff on Firth 2 demonstrated awareness of different cultural and religious beliefs, particularly in relation to patients that underwent an amputation.
- Most wards that we visited had a wet room that was wheelchair accessible.

Learning from complaints and concerns

- The trust had an up to date concerns and complaints policy in place.
- Seven of the nine clinical directorates met the target of answering 85% of complaints in 25 days.
- All areas displayed information on how to make a complaint and leaflets were available to patients and relatives.
- Staff were able to describe complaint procedures, the role of the Patient Partnership Department and the mechanisms for making a formal complaint.
- Ward managers told us they would listen to informal complaints to try and resolve them. The service kept a log of informal complaints.
- Staff gave an example of changes made following a patient complaint about telephones ringing at night. The ward changed to a flashing light system on the telephone at night in response to this.

Are surgery services well-led?

Good

The leadership of the service was good. We found;

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

However;

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

Vision and strategy for this service

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

Governance, risk management and quality measurement

- Clinical directorates held monthly multidisciplinary governance meetings. We reviewed eleven sets of meeting minutes and noticed mixed levels of attendance. There was evidence of key themes around incidents and lessons learnt, complaints and a review of risks in clinical directorates, however, there was limited evidence of lessons learnt being shared between clinical directorates and care groups. However, it was acknowledged that key notes from the trustwide safety and risk management board where lessons from serious incidents were shared were circulated to staff.

- Where issues had been identified, they had been investigated. This included undertaking external reviews. Some reviews had taken longer than expected and this meant findings and actions were not always implemented in a timely manner.
- Directorate governance leads told us medical engagement in governance had improved. Senior nurses and governance leads met across directorate with care groups, but there was not a similar forum for medical governance leads to meet.
- Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact. All risks entered on the trust risk management system were assigned a current and target risk rating. Staff identified controls were to mitigate the level of risk and progress notes were recorded. Directorate risk registers identified areas such as staffing, overruns in cardiac theatre and patient bathroom facilities.
- Most of the management team and senior staff were aware of the issues on the risk register and agreed they were representative of the risks they identified in their clinical directorate.

Leadership of service

- Staff told us they felt senior staff and managers were visible, approachable and supportive and that they received appropriate support to allow them to complete their jobs effectively.
- There had been changes to leadership for staff in cardiac theatres and the surgical secretaries. All staff spoke positively of the change; managers engaged staff, focussed on patient care and were supportive and accessible.
- All staff explained that they would be happy to approach senior staff to raise concerns and that the issues would be dealt with in a timely manner.
- Junior doctors told us they felt supported and there was always a senior member of staff to ask for support.
- We met with clinical directorate managers who felt supported and engaged with the executive team.
- The matrons met monthly with senior ward staff.
- Senior staff told us they could access support and leadership courses to help them in delivering services.
- Staff on wards knew the Chief Executive and members of the executive team.
- Ward managers had dedicated management time when they were not expected to be providing clinical care. This allowed them to focus on management and administrative issues.
- We observed a gap in leadership on Huntsman 7
- The management team were aware of the impact on morale of staff moves to different wards.

Culture within the service

- All members of staff we spoke to were proud to work in the trust and they spoke positively about teamwork and the care they provided to patients.
- Staff conveyed a strong open and honest culture in all areas that we visited during our inspection.
- The operating services, critical care and anaesthesia care group developed a behaviours framework to support staff deliver a high quality service to patients. We saw staff in theatre displaying these behavioural standards during our inspection.
- Staff told us they felt supported to report near misses, incidents and raise concerns to their line managers.
- Staff felt supported to develop their skills and progress their careers. Many staff we spoke to had worked at the trust for many years, and had achieved career progression in clinical, nursing or management roles through education and support available from the trust.
- Nursing staff morale was sometimes low due to their being moved to cover vacancies on other wards too frequently. Some staff had left the trust because of the frequency of ward moves.

Public engagement

- During our visit we saw wards displayed FFT results and cards sent by patients and relatives in 2015.
- We saw evidence of public engagement at ward level. Huntsman 3 displayed a board showing word clouds about what worked well. Examples of words were staff, team, helpful, management and for what could be improved, examples of words were environment, staffing levels, capacity, patient experience.
- The trust sought feedback from patients using the frequent feedback inpatient survey.
- Patient governors were involved in staff recruitment interviews.

Staff engagement

- As part of listening into action, the trust completed a pulse check asking staff 15 questions, for example,

'managers and leaders seek my views about how we can improve our services' and 'communications between senior managers and staff is effective.' The 2015 results were better than the trust's 2014 results and better than the average of healthcare organisations.

- All staff we spoke to felt that communication within the trust was good.
- We saw evidence that areas were involved in the trust's listening in action scheme. Leaders in theatre introduced a weekly half hour huddle after staff commented that teams did not meet regularly. The Bev Stokes Day Unit introduced 'on the spot' complaints where staff sought to resolve patient complaints at the time.
- The hand unit held a monthly HIT (hand unit improvement team) meeting, which was a forum for staff to suggest how to improve the service. From this meeting the relative's room was moved upstairs to be more comfortable for relatives and less intrusive to patient flow downstairs.
- Staff meetings took place on most of the wards we visited. We reviewed minutes of these meetings.
- Staff and ward managers told us there was an open door policy for staff to discuss issues.
- Staff were engaged in quality and service improvement. Staff told us of a "perfect day" held in theatre, where staff suggested service improvement ideas. The trust ran initiatives such as "give it a go week" and "a right good week" where staff suggested and tried out ideas to improve services and patient experience.

Innovation, improvement and sustainability

- Staff told us the Microsystems Coaching Academy worked well to support small scale service improvements.
- The trust was committed to the development of advanced nurse practitioners to ensure patient care was maintained and mitigate the potential recruitment difficulties to junior doctor posts.
- The duty floor anaesthetist role in theatre developed in Sheffield was going to be used by the Royal College of Anaesthetists as a beacon of good practice.
- The operating services, critical care and anaesthesia care group developed "The Magnificent 7", a document outlining seven areas for achievement in the department. The seven areas included zero harm, making every operating minute count and transformation through technology. Each area had a lead, an executive sponsor, an action plan and a review date.
- General Surgery had redesigned pathways and introduced rapid assessment, ambulatory working and semi-emergency clinics.
- Staff in the hand unit redesigned the trauma service. A consultant, nurse and junior doctor led a daily trauma clinic. Staff in the emergency department could book patients directly into this clinic. If a patient required surgery, they were given an appointment for surgery at the clinic.
- A nurse was shortlisted for "Nurse of the Year" award for their work in setting up one of the largest centres in Europe to use easy-to-swallow pill cameras to diagnose bowel problems.
- The podiatry service had been awarded Customer Service Excellent Award for the 15 consecutive years.

Critical care

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

Information about the service

Sheffield Teaching Hospitals NHS Foundation trust provided critical care services at the Northern General Hospital (NGH). The General Intensive Care Unit (GITU) had 15 beds; General High Dependency Unit (GHDU) had 16 beds. GITU and GHDU were located over two floors. The Cardiac Intensive Care Unit (CICU) had 12 beds and was adjacent to Cardiac Theatres. The Progressive Care Unit (PCU), which provided care for patients after cardio-thoracic (heart or lung) surgery, had six beds and was located beneath CICU on Chesterman unit. Osborn wards provided spinal injuries services in the Spinal Injuries Unit. There were six beds equipped to care for patients who required the assistance of a ventilator (breathing support machine).

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

Between December 2014 and November 2015, there were 1139 admissions to CICU, 1768 to GHDU and 801 to GICU.

A critical care outreach team provided a supportive role for medical and nursing staff when dealing with deteriorating patients and supported those patients discharged from GICU to wards within the hospital. The team was managed from the GICU and available Monday to Friday 8.00am to 4.00pm. Advanced Nurse Practitioners (ANP's) followed up cardiac intensive care patients who were discharged to the PCU or other wards within the hospital.The NGH critical care services were part of the North Trent Critical Care Network.

We visited the GICU, GHDU, PCU, Osborn 1 and Osborn 3. We spoke with five patients, four relatives and 56 staff, including junior and senior nurses, health care assistants, junior and senior doctors, allied health professionals, administrative and housekeeping staff. We observed interactions between patients, their relatives and staff and we considered the environment. We reviewed 12 medical, nursing and allied health professional care records and twelve medication prescription charts.

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

Critical care

Summary of findings

The safety of this service was good. Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Performance showed a good track record and steady improvements in safety. For example, there were a low number of infections such as Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium difficile (C.difficile). Staffing levels and skill mix were planned and reviewed to keep people safe at all times. Systems, processes and standard operating procedures for infection control, medicines management, patient records and the monitoring and assessing and responding to risk were mostly reliable and appropriate to keep patients safe. However, we found the system for maintaining medical equipment was not always reliable on CICU.

We judged the effectiveness of this service to be good because patients had comprehensive assessment of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs. When patients were due to move between services, their needs were assessed with the involvement of all the necessary staff. Staff worked collaboratively to understand and meet the range and complexity of patient's needs. Staff were qualified and had the skills they needed to carry out their roles effectively. Staff had access to the information they needed to assess, plan and deliver care to patients in a timely way. Care and consent to treatment was obtained in line with legislation and guidance. Where patients lacked mental capacity to make a decision, 'best interest' decisions were made in accordance with legislation. However, information about patients care and treatment, and their outcomes, was not routinely collected or monitored within the cardiac intensive care unit therefore the service was unable to benchmark itself against other similar services.

The care provided to patients in critical care was outstanding. Patient's emotional and social needs were highly valued by staff across all units and were embedded in their care and treatment. Feedback from patients who used the service was continually positive about the way staff treated them. There was a strong, visible patient centred culture. We saw the use of hand signals, body language and facial expressions. On a unit, with a patient who was living with dementia, staff were seen positively interacting with the patient to ease anxiety. Staff recognised and respected the totality of patient's needs. We saw the use of patient name boards, which included 'what matters most to me today'. One patient wished to watch a specific television programme at a certain time. We noted the nurse ensured the patient had the television tuned to the correct channel at the specific time. Without exception patients across all units were treated with dignity, respect and kindness during all interactions with staff. We saw where staff had gone that extra mile to exceed patient's expectations, for example the planning and use of the garden on GICU and the facilitating of a patient's dog to attend the garden. Staff responded compassionately when patients needed help and support to meet their basic personal needs. For example, we saw how a patient with a learning disability had been woken up following surgery on GICU rather than in theatre recovery, so that they were familiar with the staff caring for them.

We found the responsiveness of this service to be outstanding because services were tailored to meet the needs of the individual patient. There was a proactive approach to understanding the needs of different groups of people. Care was delivered in a way that met these needs. For example, we saw the use of distraction therapy and a special activities box for a patient living with dementia. There was an innovative approach to providing integrated patient centred care pathways. We saw an example where the care of a patient with mental health needs had involved other services. Access to care was managed to take account of peoples need, including those with urgent needs. There was openness and transparency on how complaints and concerns were dealt with. Improvements were made to the quality of care as a result of complaints and concerns; this included staff working through examples of real complaints as part of their mandatory training.

The leadership of critical care service was good because leaders prioritised safe, high quality person-centred care. There was a clear statement of vision and values, driven by quality and safety. There was an effective and

Critical care

comprehensive process in place to identify, understand and address current and future risks. There was a strong focus on continuous learning and improvement. The services proactively engaged and involved staff and ensured that the voices of all staff were heard and acted on. Staff innovation was supported and there was a high level of staff satisfaction. However, not all leaders had the necessary experience in critical care.

Are critical care services safe?

Good

The safety of this service was good. We found;

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

However we found;

The system for maintaining medical equipment on CICU was not always reliable.

Incidents

- Staff we spoke with were aware of, and appeared knowledgeable and confident about reporting incidents. All staff had access to the online reporting system; staff gave us examples of when they might report incidents such as a pressure ulcer. Staff said there was a no blame culture in the service and they felt empowered to report incidents without fear of reprisal.
- Staff told us they received individual feedback for incidents they reported.
- Incidents giving cause for concern or following a specific trend were discussed, for example, in the ward meetings, handover or through a ward newsletter. We saw evidence of this in ward meeting minutes and during ward handovers.

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- There were 360 incidents reported between December 2014 and August 2015. Drug related incidents made up the largest group of incidents. These were for a variety of reasons, for example a drug not being available. Other incidents included pressure ulcers and general care. Incidents were reviewed and appropriately investigated by the designated people, for example ward managers or matrons.
- Following an incident in one of the units involving injecting potassium medication into an infusion, we saw pre made potassium bags were now available to minimise the risk of the incident happening again.
- The new regulation, Duty of Candour (DOC), states providers should be open and transparent with people who use services; it sets out specific requirements when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, giving truthful information and an apology. Most staff we spoke with was aware of duty of candour.
- There were regular mortality and morbidity meetings to share learning from the deaths of patients. Doctors, nurses and therapists working in critical care attended the meetings. Staff on CICU told us they did not get to attend these meeting due to staffing levels, although they did receive minutes from these meetings through email, but it was not always possible to access a computer to read these in a timely way.

Safety thermometer

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. It focuses on four avoidable harms: pressure ulcers, falls, urinary tract infections in patients with a catheter, and blood clots or venous thromboembolism (VTE).
- There were 17 pressure ulcers recorded between July 2014 and July 2015.
- The safety thermometer information was displayed in most clinical areas for staff, patients and visitors to see, this showed the numbers and trends of the avoidable harms, for example pressure ulcer and falls.

Cleanliness, infection control and hygiene

- The data from October 2014 to March 2015 submitted and verified by the Intensive Care National Audit and Research Centre (ICNARC) showed that GICU and GHDU performed in line with similar units for unit acquired Methicillin Resistant Staphylococcus aureus (MRSA) and Clostridium.difficile infection rates. MRSA and C.difficile are infections capable of causing harm to patients. MRSA is a type of bacterial infection and is resistant to many antibiotics. C.difficile is a bacteria affecting the digestive system; it often affects people who have been given antibiotics.
- In the reporting period April 2014 to April 2015, there were 13 unit-acquired infections on CICU, two of which were MRSA
- In the same reporting period, there were two unit-acquired infections on GICU and seven on GHDU; none of these were MRSA or C.difficile.
- Critical care had been accredited by the hospitals internal Infection Control Accreditation Programme. This programme set standards for infection prevention and control practice with the aim to optimise and assess infection prevention and control practices in clinical teams throughout the hospital to reduce infection rates.
- Cleansing gel was available at the entrances to each area and in each room; patients and visitors were encouraged to use it by staff. Posters were prominently displayed encouraging staff and visitors to cleanse their hands and the process to follow to do this effectively.
- Staff were 'bare below the elbow' to allow effective hand washing.
- Protective equipment, such as gloves and aprons, were available and we observed staff using this appropriately. We also observed staff washing their hands between patients.
- Compliance with key trust policies, such as hand hygiene, central venous catheter care and ventilator associated pneumonia was monitored through quarterly audits.
- During reporting period December 2014 to September 2015, hand hygiene compliance on the Cardiac Intensive Care Unit (CICU) and Progressive Care Unit (PCU) was 100 % and on the General Intensive Care Unit (GICU) between 93% and 100%.
- In the same reporting period, there was a 100% compliance with all care bundles such as Ventilator Associated Pneumonia (VAP) and Central Venous Catheter (CVC) insertion and ongoing care. A care bundle is a structured way of improving processes of care and patient outcomes.
- We saw there were side rooms with differential pressure ventilation. Differential room pressure is an isolation technique used to prevent cross-contaminations from

room to room. It includes a ventilation system can generate negative or positive pressure to allow air to flow into the isolation room but not escape from the room; this prevents contaminated air escaping from the room. This helps to minimise the risk of spreading infections.

- There was an effective system for the cleaning and decontamination of equipment. Audits demonstrated 100% compliance for every audit between December 2014 and September 2015.
- There was an effective system for the cleaning and decontamination of equipment for example 'I am clean' stickers. These were clearly visible, dated and signed appropriately. Audits demonstrated 100% compliance for every audit between December 2014 and September 2015.
- We observed patient-care equipment to be clean and ready for use. We found five humidified oxygen sets in the store room on GHDU and eight on PCU had been prepared ready for use. However, there was no evidence to suggest how long these had been ready for use and we noticed some of the tubing was exposed to the atmosphere. This meant they were at risk of contamination. We escalated our concerns to a member of the technical team at the time.
- Processes and procedures were in place for the management, storage and disposal of general and clinical waste including the disposal of sharps such as needles and environmental waste.

Environment and equipment

- The GICU and GHDU were located on separate floors above each other but staff told us they worked as one unit. CICU was located adjacent to cardiac theatres with PCU located on the floor below.
- The areas on GICU, GHDU and CICU were spacious with sufficient room for the equipment required in each bed space. The areas utilised natural light to assist patients' sensory awareness.
- Each bed space was suitably equipped and able to manage the care and treatment of a level three patient. There was sufficient equipment for all patient bays to be utilised.
- The PCU was a six-bedded unit situated on the floor immediately below CICU. The environment was small and appeared cluttered within minimal space around the bedside. Nursing staff told us the unit had originally been part of two cardio-thoracic wards situated either side of the unit and felt the environment was not always suitable for the type of patients accommodated in this area.
- Resuscitation and emergency/difficult intubation equipment was available in all patient areas with the exception of CICU. The emergency intubation equipment for CICU was located in theatres opposite the department. Staff were aware of its location in the event of an emergency. Standards published by the Intensive Care Society in 2014 state that all critical care areas should have their own 'Difficult Airway' trolley. Intubation is the placement of a flexible plastic tube into the trachea (windpipe) to maintain an open airway.
- The resuscitation equipment, emergency and difficult intubation equipment and emergency transfer bags on the wards had been checked daily by staff and were safe and ready for use. Single-use items were sealed and in date, and emergency equipment had been serviced regularly to maintain safety.
- There was a system for reporting repairs and maintenance of equipment. Staff told us equipment in the unit was treated as a priority for repairs and maintenance. We saw repairs were dealt with promptly. Data provided by the hospital showed on the 1st October 2015 92% of devices had been serviced within one month of their due date against a target of 90%.
- We found one infusion pump on CICU was three months late with a medical engineering check. The pump was not in use at the time; however, a discontinued infusion was still in the pump. It was removed immediately following escalation to the ward sister. Four infusion pump charging stations on CICU were between one and three months past their medical engineering service date and 12 oxygen, suction and electrical points in the bed spaces were two years overdue for service. We spoke with the medical engineering department about this, there was a rolling plan due to commence in January 2016 to replace and service all equipment within CICU, a risk assessment was in place. On GHDU a portable electrocardiogram machine (machine used for obtaining a heart tracing), was two months out of date with a portable appliance test and one month over due to medical engineering testing; this was not seen to be used during out visit to the unit.
- Fire-fighting equipment had been maintained and tested.

- Equipment was available for bariatric (overweight) patients, for example larger commodes, hoists and chairs.
- There was access to showers on GHDU/ GICU with a piped oxygen supply. This meant patients who were being assisted with their breathing through a ventilator (breathing machine) could have a shower.
- The trust was reaching the end of a tendering process for the replacement of the ventilators used by all critical care departments, and a decision was expected to be made by the end of December 2015 as to which product would replace the current ventilators.

Medicines

- There was a centrally located pharmacy on GICU and GHDU and pharmacy technicians worked as part of the team to ensure there was sufficient stocks and supply of medications. CICU and PCU had access to main pharmacy and pharmacists visited the wards.
- We looked at the electronic and hand written prescription and medicine administration records for twelve patients on the various wards. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed people were getting their medicines when they needed them. Records of patients' allergies were recorded on the prescription chart.
- An advanced clinical pharmacy service had been developed to improve the safety and efficacy of medicines used in GICU and GHDU. A consultant pharmacist led the clinical pharmacy service. The critical care pharmacy service provided specialist pharmacy cover for the critical care areas, ensuring medications were prescribed and used in a cost, clinically effective and safe manner. The clinical pharmacy service had a number of prescribers, enabling them to immediately prescribe or correct prescription errors. This supported timely administration of the correct medications and allowed medical staff to undertake other roles.
- There was a dedicated senior clinical pharmacist allocated to critical care with expertise in critical care. The pharmacist attended the daily multidisciplinary ward rounds.
- The medicines storage room and fridges had their temperatures monitored and recorded daily to ensure medicines were safely stored.
- Medicines stored in the fridge were labelled with the date they had been opened.
- There was electronic prescribing on some of the units; other units had critical care specific drug prescription charts. Hand written drug prescription chart were written when patients were discharged or stepped down to the wards.
- There was standardised medication prescribing and use across the whole of the critical care departments. This ensured consistency throughout the trust that patients received the best possible care.
- Antibiotics had start, stop and review dates on the patient's medicines administration record. There were local microbiology protocols in use for the administration of antibiotics. A consultant microbiologist was part of the daily ward round to promote and ensure good antibiotic use.
- Intravenous fluids were stored in an unlocked cupboard on GICU. This did not meet current guidance. Intravenous fluids should be stored in a locked room with restricted access; we were told this had been risk assessed and there were plans in place to put a lock on the door.
- Medicines were mostly stored appropriately. On one area we visited, we observed a syringe full of medication left unattended by the patient's bedside, although staff were in the immediate vicinity, this was against the hospital policy.

Records

- We looked at 12 patient records across all of the departments. Records were a mixture of paper in some areas and electronic in other areas. Access to electronic records was through a bedside computer. This allowed for easy access for all staff caring for the patient.
- All notes we saw were stored in a way that minimised the risk of unauthorised access.
- We saw computers were locked when not in use to avoid any unauthorised access.
- An electronic clinical information system was in use on GICU and GHDU. This automatically recorded physiological observations. Though observations were recorded automatically, they had to be validated by the nurse at the bedside; this included ventilator settings.
- All patient records we looked at included a range of clinical entries, assessments and plans. These included, for example, nutritional risk, falls assessments, physiotherapy treatment plans and skin bundles.

- Patient records were multidisciplinary and we saw where nurses, doctors and allied health professionals had made entries.
- All entries were legible, up to date and accurately reflected the outcome of assessments. For example, where a skin assessment had shown a risk to the patient of developing a pressure ulcer, additional plans of care had been put in place.
- All of the appropriate records we reviewed had the time and decision to admit to Intensive Care recorded; this was in line with best practice.

Safeguarding

- There was an internal system for raising safeguarding concerns and staff were aware of the process and could explain what constituted abuse and neglect.
- A direct link was available from the electronic clinical information management system so staff on GICU and GHDU had easy access to make safeguarding referrals should they be required. CICU and PCU had access through the trust intranet. Nursing staff told us about a recent safeguarding referral they made when they had been concerned about the safety of children.
- Staff received safeguarding of vulnerable adults training (level two), safeguarding children, and young people (level one) as part of their mandatory training. Completion rates for nursing staff were between 81%-94% against the trust target of 90%. Completion rate for medical staff was low between 36%-57%; this did not meet the trust target of 90%. We discussed this with the senior management team and they explained this was due to a recent change in the way training was recorded for new doctors in the trust. There was a plan in place to address this issue. The trust had also recently introduced a new safeguarding training module.

Mandatory training

- Mandatory training for all groups of staff was comprehensive; modules included moving and handling, infection control, fire safety and resuscitation.
- Mandatory training data for nursing staff showed a varied completion rate of between 83% and 94% against the trust target of 90% for the core modules. Completion rate of medical staff was low between 19%- 88% and did not meet the trust target of 90%.We discussed this with the senior management team and this was due to a recent change in the way the training was recorded for new doctors in the trust. There was a plan in place to address this issue.

Assessing and responding to patient risk

- We saw nurses carrying out a safety check of the bed area at the start of each shift. This included oxygen and suction. The safety check was recorded on the clinical patient information system where this was available.
- The Sheffield Hospitals Early Warning Score (SHEWS) Early warning score was used throughout the trust to monitor patients and identify when their condition may be deteriorating. Early warning scores have been developed to enable early recognition of a patient's worsening condition by grading the severity of their condition and prompting nursing staff to get a medical review at specific trigger points.
- Staff were expected to complete the early warning score e-learning package to familiarise themselves with the completion of EWS. This was not mandatory however it was part of job specific training and was required to be completed every three years..
- There were standard operating procedures covering in and out of hour's escalation of the deteriorating patient; these were available on most wards. However, we spoke with nursing staff on Osborn one and three and found there to be no standard or consistent approach to escalating the deteriorating patient with a tracheostomy if this became blocked. A tracheostomy is an artificial opening into the windpipe (trachea) and is held open by a tracheostomy tube.
- Staff did not have immediate access to the emergency tracheostomy management algorithm to support them in an emergency as recommended in the 2014 Intensive Care Society tracheostomy standards. There were no emergency anaesthetic medications on the ward, and staff did not know where these were located. Anaesthetic medications would be required in an emergency by an anaesthetist should an emergency intubation be required. Intubation is the placement of a flexible plastic tube into the trachea (windpipe) to maintain an open airway.
- There was no standardised way of knowing which tracheal tube a patient had on Osborn one and three, which meant there may be some delay in replacement

in the event it became blocked. Good practice in the 2014 Intensive Care Society tracheostomy standards states a simple sign above the bed should be displayed to facilitate this.
- We escalated our concerns to the trust and when we returned two days later during our inspection, all of the issues had been addressed including the addition of emergency tracheostomy boxes on the resuscitation trolleys.
- The critical care outreach team consisted of four whole time equivalent nurses and was available Monday to Friday between 8.00am to 4.00pm. Out of hours, cover was provided 24/7 by a dedicated anaesthetic trainee for referrals and deteriorating patients over and above the cover for the critical care areas. The outreach team provided a supportive and educational role for medical and nursing staff when dealing with a deteriorating patient. They also provided support and training to staff in developing the skill and confidence in managing complex patients. In conjunction with the local university, a course had been designed. All new doctors were expected to attend when they started at the trust. This was called the Sheffield Management of Acutely Ill patient, Recognition and Treatment (SMART).
- The critical care outreach team followed up all patients who had been in GITU and patients who had been in GHDU for three days or more. There was no outreach service for CICU or PCU patients; however, an Advanced Nurse Practitioner (ANP) followed up these patients.
- Risk assessments were carried out including pressure ulcer risk and the risks associated with moving and handling the patient. Individual patient risks were reviewed at least daily to ensure they were kept up to date.
- Patient observations were taken and recorded at the required frequency including ventilator observations. Appropriate action was taken in response to changes in observations.
- There was a standard operating procedure covering all aspects of the intra-hospital transfer of patients requiring a higher level of care which staff were aware of.
- We saw a multi-disciplinary handover document in use, which promoted safe practice, and consistent use of local guidelines.

Nursing staffing

- The Intensive Care Society and British Association of Critical care Nurses (BACNN) standards were used for assessing patient acuity and determining the number of staff required on each shift. The staffing allowed for one to one nursing for level three patients and one nurse for every two level two patients. This met the 'Core Standards for Intensive Care Units' published by the Intensive Care Society (ICS). The staffing was adjusted according to demand as the numbers of level two and three patients could change.
- Nursing staffing levels were monitored against the planned levels. We found adequate staffing to meet peoples care needs and which were in line with national guidance.
- Shortfalls in staffing levels were met by using in-house bank staff or external agency staff. In-house staff were always contacted first for any cover required and agency staff were used as a last resort.
- The use of agency nurses was low, ranging between 0.2% and 3.8% over the period April 2014 to March 2015
- There was a supernumerary clinical co-ordinator per shift on most units. Clinical co-ordinators provide clinical nursing leadership, supervision and support when there were six or more patients. This met the Core Standards for Intensive Care Units. PCU did not have a supernumerary clinical co-ordinator; this role had been removed in the last year. Whilst there is not a requirement to have one on this unit, the issue had been raised in a senior nurses meeting because there had been an increase in medication incidents, for example being unable to administer medications at specific times as a result because staff were so busy.
- The units had a number of band 6, and above, specialist nurses in the staffing establishment. This included a rehabilitation nurse lead, an audit, quality nurse lead, and full time practice educators.
- Advanced Nurse Practitioners (ANP) supported the delivery of care to patients and were part of the medical rota.
- We saw the use of Assistant Practitioners who supported nursing staff with level two patients.
- Nurses were often moved to other wards where there were gaps in staffing. Some nurses on CICU told us this happened frequently and they were often asked to take charge of other areas. The matron told us on 49 occasions during August 2015, staff were moved to other wards. She was trying to address this issue with the senior hospital teams. Nursing staff told us they were unprepared for work on other wards as the work differed to that on CICU.

- There was a standardised approach to handover. This was communicated as a large team and a specific handover at the patient's bedside. Handovers on GICU and GHDU were recorded on the clinical patient information system.

Medical staffing

- There were designated clinical leads for critical care.
- The units operated a closed unit model with critical care doctors responsible for planning the care of patients. A closed unit model refers to all admission, discharge and significant management decisions of the patients within the units being made by an intensive care consultant.In aclosed model, the intensive care consultantstakes over the primary responsibility for the care of the patient and is ultimately responsible for all decisions made within critical care.In open models, the team who was originally caring for the patient for example surgeons keeps formal responsibility for the patient and their treatment. Closed models have been associated with reduction in mortality.
- There were 15 whole time equivalent (wte) consultants covering GICU and GHDU. All consultants were Faculty of Intensive Care Medicine accredited (FICM); this met with the Core Standards for Intensive Care Units.
- There were 11 wte consultants covering CICU. Not all consultants on CICU were Faculty of Intensive Care Medicine accredited (FICM).This was because some consultants did not have a daytime commitment to cover critical care; this did not meet the Core Standards for Intensive Care Units. The standard states that all consultants in intensive care medicine will have daytime clinical care programmed activities in intensive care medicine written into their job plan.
- On GICU the consultant to patient ratio during the daytime did not exceed the range of 1:8 to 1:15 and so met with the Intensive Care Society standard.
- On CICU, the consultant to patient ratio met with the ICS standard of 1:8 to 1:15.
- The Intensive Care Society standards recommend that consultant work patterns should deliver continuity of care and suggest a five day block. GICU / GHDU consultants covered a one or two-day block on the unit therefore we could not be assured that patients always received full continuity of care.
- There was medical cover available 24 hours a day seven days per week. Cover was by an anaesthetic registrar. GICU had dedicated medical cover by an anaesthetic registrar who did not have commitments to other clinical areas, cover in CICU was provided by a registrar who had commitment to other areas. Out of hours consultant cover on CICU was shared with cardiac theatres and the cardiac catheter laboratory. This fell short of the Core Standards for Intensive Care Units, as consultants participating in the on call rota must not be responsible for delivering other services such anaesthesia whilst covering the critical care unit.
- All consultants were able to attend the unit within 30 minutes if required. However, we were not assured this would be possible on GICU /GHDU as the consultant was covering two sites, and the CICU consultant may well be in theatre or the cardiac catheter laboratory.
- There was a structured clinical standardised approach to handover. Handovers were formally recorded on an electronic records system on GICU/GHDU and through a written sheet, which was provided to the nurse in charge on CICU.
- In the reporting period, April 14 to March 15 there was a low locum usage of 2.2%.
- Nurses and junior doctors in the units told us advice and support from consultants was readily available, including out of hours.

Major incident awareness and training

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

Critical care

Are critical care services effective?

Good

We judged the effectiveness of this service to be good because patients had comprehensive assessment of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs. We found;

- When patients were due to move between services, their needs were assessed with the involvement of all the necessary staff.
- Staff worked collaboratively to understand and meet the range and complexity of patient's needs.
- Staff were qualified and had the skills they needed to carry out their roles effectively.
- Staff had access to the information they needed to assess, plan and deliver care to patients in a timely way.
- Care and consent to treatment was obtained in line with legislation and guidance.
- Where patients lacked mental capacity to make a decision, 'best interest' decisions were made in accordance with legislation

However;

- Information about patients care and treatment, and their outcomes for example the Intensive Care National Audit and Research Centre (ICNARC) data, was not routinely collected or monitored in the cardiac intensive care unit therefore the service was unable to benchmark itself against other similar services.

Evidence-based care and treatment

- Most units used a combination of national and best practice guidance to determine the care they delivered. These included guidance from the Intensive Care Society, National Institute for Health and Care Excellence (NICE) and National Confidential Enquiry into Patient Outcomes and Death (NCEPOD).
- We saw most units were adhering to NICE guidelines, for example referrals to the organ donation teams.
- We reviewed several aspects of care being delivered from both a nursing and medical perspective. Many aspects of nursing care were based on the use of care bundles for example, ventilator care bundles. Such bundles were evidence based and aligned to best practice guidance. We also saw brain stem testing carried out using nationally recommended proformas.
- Compliance with key trust policies, such as, central venous catheter care and ventilator associated pneumonia were monitored through quarterly audits. In the reporting period December 2014 to September 2015 there was a 100% compliance with all care bundles such as Ventilator Associated Pneumonia (VAP) and Central Venous Catheter (CVC) insertion and ongoing care.
- There were designated quality and audit nurses as well as data analysts in post who managed the wide ranging unit audit programme and various data submissions.
- There was a local audit calendar. Audits scheduled to be carried out included the management of hypoglycaemia in critical care. Audits were discussed at clinical governance meetings.
- There was a standardised handover procedure for patients discharged from the unit to the wards. A unit nurse accompanied the patient to the ward and gave a formal written and verbal handover. This included information such as a summary of the patient's care and treatment in the unit, a plan for on-going treatment, and any follow up requirements. This met the Core Standards for Intensive Care Units. On CICU, an additional step had been added to this process and the nurse in charge of the receiving ward came to CICU for an additional handover. This meant a suitable bed space could be facilitated on the receiving ward, for example if the patient required closer observation.
- We reviewed two weaning plans on CICU for patients with tracheostomies and found these were inconsistent and not made in a timely way. We saw that one patient who required a weaning plan, did not have one in place. This meant there might be a delay in a patients discharge from critical care and rehabilitation. A tracheostomy is an artificial opening into the windpipe (trachea) and is held open by a tracheostomy tube. This helps people to breathe more easily. Weaning is reducing the amount of ventilator support a patient receives in order to facilitate them breathing independently. A ventilator is a breathing support machine.
- All patients were screened for delirium at least daily. Delirium is an acute medical condition and a common

occurrence in critical care units. Patients with delirium are likely to spend longer in hospital and have an increased risk of long-term cognitive impairment or death.

- There was a range of local policies, procedures and standard operating protocols in place, which were easily accessible through the trust wide intranet and directly available through the electronic records system.
- We saw there was a variety of nurse led protocols in place to support a speedier recovery and discharge from critical care. For example, a nurse led extubation protocol. This meant there would be minimal delays in waking a patient when the time was appropriate. Extubation refers to removal of the breathing tube.
- On GICU and GHDU there had been an adaptation of an electronic care management system to manage and share information needed to deliver fully integrated effective care. The system also provided real time information across teams and services. For example, there was prompting of basic tasks before moving onto another task. This ensured care elements were not missed. Other examples included being able to review microbiology results and trends in a real live system and joint up working with other members of the multi-disciplinary team for a real time view of the care and progress of the patient. Treatment plans could be adapted quicker as a full at a glance status was seen.
- A specific critical care pharmacist was available across all units and was instrumental in the education of staff about protocols for drugs; this meant patients received the most up to date evidence based medicines care available.
- A Consultant Pharmacist working on GICU / GHDU had developed a guideline for management of delirium. We saw that this was available on the electronic patient information system and staff were following this guidance.
- Most nursing staff had access to the critical care-learning zone accessed through the trust intranet this provided updates on policies, procedures and new evidence based guidance / protocols pertinent to the critical care area.
- Sedation breaks were implemented where appropriate. A sedation break is when a patient's sedative infusion is stopped to allow them to wake and has been shown to reduce mortality and the risk of developing ventilator related complications. The sedative is then re-started if the patient becomes agitated, in pain or in respiratory distress.

Pain relief

- As part of their individual care plan, all patients in critical care were assessed in respect of their pain management. This included observing for the signs and symptoms of pain. Staff utilised a pain-scoring tool for patients who were awake and those patients who were ventilated (receiving breathing support through a tube).
- Pain relief and sedation for patients were recorded at the same time as physiological observations. The patient's response was monitored and changes were made to medicines as necessary.
- Patients and relatives told us staff responded quickly if a patient appeared to be in pain or distress.
- There was access to the pain management team for support and guidance.
- We saw during our inspection where a patient was given pain relief prior to being woken up to reduce any discomfort when they awoke.

Nutrition and hydration

- All patients were screened for malnutrition and the risk of malnutrition on admission to the hospital using an adapted Malnutrition Universal Screening Tool (MUST).
- We saw the use of the hydration and nutrition assurance toolkit (HANAT) on critical care. This supported staff to meet the hydration and nutritional needs of patients.
- We observed a standardised feeding plan for patients who were being fed by nasogastric tube (NG) or percutaneous endoscopic gastrostomy tube (PEG). This meant there was no delay in the feeding of patients if a dietician was not available. A NG tube is a narrow bore tube passed into the stomach through the nose. It is used for short- or medium-term nutritional support. A PEG tube is a flexible feeding tube, which is placed through the tummy wall and into the stomach. PEG allows nutrition, fluids and/or medications to be put directly into the stomach.
- There was strict fluid balance monitoring for patients, which included hourly and daily totals of input and output.
- There was access to a Speech and Language Therapist (SALT) and dietetic service. We were informed a dietician attended the unit when required.

- Some nursing staff had been trained to carry out swallow assessment so that there would be no delay in feeding patients if a SALT was not available.

Patient outcomes

- The units engaged, participated and contributed in the North Trent critical care network. This included audit activity and regular benchmarking against other Critical care services in the region.
- CICU did not demonstrate continuous patient data contributions to the Intensive Care National Audit and Research Centre (ICNARC). This meant the care delivered and mortality outcomes for patients were not benchmarked against similar units nationally, the unit planned to submit their first data set following our inspection.
- GICU and GHDU participated in the national annual audit of critical care services by the Intensive Care National Audit and Research Centre (ICNARC). This meant the outcomes for patients using the critical care service could be measured against outcomes achieved by similar services.
- The results from the latest ICNARC data available to us at the time of our inspection was for October 2014 – March 2015, showed patient mortality rates for GICU within the expected ranges when compared with similar units nationally and these had remained stable.
- Unit acquired MRSA and C.difficile infections were similar to other units.
- Enhanced Recovery After Thoracic Surgery (ERATS) had been implemented on CICU this had led to a reduction in complications, length of stay and halved the readmission rate to CICU. ERAS is a perioperative care pathway designed to achieve early recovery for patients undergoing major surgery. The central elements of the ERAS pathway address key factors that keep patients in the hospital after surgery which include the need for intravenous pain relief, the need for intravenous fluids secondary to gut dysfunction and bed rest caused by lack of mobility.
- Single port access endoscopic surgery had reduced length of stay on CICU. Single port access endoscopic surgery is a procedure in which the surgeon operates almost exclusively through a single entry point.
- Nursing staff told us and we saw from reviewing medical notes, twice-daily bedside ward rounds did not routinely take place. Core Standards for Intensive Care Units state the consultant must see all patients at least twice daily (including weekends and National holidays) and set a management plan, in the form of a structured bedside ward round.

Competent staff

- There were dedicated clinical nurse educators responsible for coordinating the education, training and continuing professional development of critical care nursing staff. This met the Core Standards for Intensive Care Units.
- Newly appointed nurses had an induction to their role in the unit and had a supernumerary period. They had identified mentors on all shifts and worked through a competency frameworks. These competencies formed part of the annual appraisal.
- Nursing staff received an annual appraisal. The latest figures showed 94 % of nursing staff on CICU and 93 % on GICU had received an appraisal in the last 12 months against a trust target of 90%.
- Appraisal figures for the medical staff were 100% for CICU and 80% for GICU.
- Managers completed annual check of nurses registration with the Nursing and Midwifery Council.
- The percentage of nurses with a post registration award in Critical care nursing was above the requirement of 50% and ranged from 58-64%. This was soon to rise as more nurses were, at the time of our inspection, due to complete the course.
- All of the newly appointed consultants working in the units had the correct competencies as defined by the Intensive Care Society.
- A revalidation process was in place with good opportunities for training for medical staff.
- The Faculty of Intensive Care Medicine had accredited an advanced level of training in Intensive Care Echo and Basic Lung Ultrasound (ICE BLU). Echo is the scanning of the heart and ultrasound is the scanning of the lung.
- The critical care outreach team provided education and training in acute and critical care skills to staff across the trust.
- The critical care education team produced a quarterly educational update to support ongoing learning and development of nursing staff.

Multidisciplinary working

- In most areas, the multidisciplinary team (MDT) included nursing and medical staff, physiotherapists,

dietician and speech and language therapists, microbiologist, and pharmacist. Dieticians and speech and language therapists did not routinely attend ward rounds, but had input into patient care when required.

- There was an MDT approach which enabled care to be delivered in a coordinated way. Allied health professionals such as pharmacists worked well with the nursing and medical teams. On GICU, we attended the daily team handover, which included the nurse in charge, consultant, pharmacist and a physiotherapist. This discussed the care and progress of patients. On GICU / GHDU this was incorporated into the electronic recording system to see real time information in relation to the patient care for example, most recent observations.
- Patients discharged from GICU with a stay greater than three days were followed up by the critical care outreach team. There was no follow up by the outreach team for CICU patients, however most patients were stepped down to the Progressive Care Unit and then followed up by ANP's.

Seven-day services

- A consultant intensivist was available seven days a week including out of hours.
- The physiotherapy and pharmacy team provided seven days a week service to GICU with an on call service out of hours. On CICU, the pharmacist did not work weekends but staff had access to the on call service.
- Diagnostic imaging was available on call outside normal working hours. Consultant staff described during interview there were never any problems obtaining diagnostics or laboratory support out of hours.

Access to information

- All staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessments and medical and nursing records.
- There was an electronic record for each patient on GICU/ GHDU, which included medical, nursing and allied health professional's notes. Observation charts were accessible through the same system. This enabled consistency and continuity of record keeping whilst the patient was on the unit, supporting staff to deliver effective care. On CICU, notes were paper based and kept in the bed area for easy access.
- There were computers by each patient bedside on GICU /GHDU and on the unit; these gave staff access to patient and trust information for example policies and procedures. Direct links to the intranet pages were embedded in the electronic system, for example, links to the safeguarding policy if required. This saved staff time and meant they had the most up to date information at all times and they could make timely referrals if required. Other examples include links to refer a patient to the tissue viability nurse. Although CICU had access to the intranet, they said the number of computers in the department was too few, and they could not always leave the patient to access one.
- There was a formal handover for patients transferred from the units to the wards. This included information such as a summary of the patient's care and treatment in the unit, a plan for on-going treatment, and any follow up requirements. This met the Core Standards for Intensive Care

Consent and Mental Capacity Act

- Staff demonstrated understanding of the issues around consent and capacity for patients in critical care. Staff told us if they were unsure in any circumstances, they would seek guidance from senior staff or from the safeguarding lead.
- Nursing staff told us they were aware of and had used Independent Mental Capacity Advocates (IMCA). IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person if decisions about care and treatment are required.
- We saw where a best interest decision had been made when a patient lacked capacity to make an informed decision in relation to a do not resuscitate order.
- In terms of the management of delirium, there was an assessment of mental capacity recorded in the patient record. This was using a nationally recognised confusion assessment method and was used in conjunction with a nationally recognised agitation scale. Agitation scales measure the agitation or sedation level of a patient. In all of the care plans we looked at the confusion and agitations scores were recorded at least once per shift.

Are critical care services caring?

Critical care

Outstanding ☆

The care provided to patients in critical care was outstanding. Patients emotional and social needs were highly valued by staff across all units and were embedded in their care and treatment. We found:

- Feedback from patients who used the service was continually positive about the way staff treated them. We saw where staff had gone that extra mile to exceed patient's expectations, for example, the planning and use of the garden on GICU and the facilitating of a patient's dog to attend the garden.
- There was a strong, visible patient centred culture. We saw the use of hand signals, body language and facial expressions on a unit, with a patient who was living with dementia. Staff were seen positively interacting with the patient to ease anxiety. The patient responded to staff with understanding. The patient appeared calm and relaxed.
- Staff recognised and respected the totality of patient's needs. We saw the use of patient name boards, which included 'what matters most to me today'. One patient wished to watch a specific television programme at a certain time. We noted the nurse ensured the patient had the television tuned to the correct channel at the specific time.
- Without exception across all units patients we observed patient being treated with dignity, respect and kindness during all interactions with staff.
- Staff responded compassionately when patients needed help and support to meet their basic personal needs, for example we saw how a patient with a learning disability had been woken up following surgery on GICU rather than in theatre recovery so that they were familiar with the staff caring for them.
- Staff helped patients and those close to them cope emotionally with their care and treatment. A relative told us they were anxious in the middle of the night about their spouse and they persistently kept calling the unit. The relative said nothing was too much trouble and nurses provided good emotional support during every call. In the end, they told us nursing staff invited her to the hospital for more comfort.

Compassionate care

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

living with dementia. Staff were seen positively interacting with the patient to ease anxiety. The patient responded to staff with understanding. The patient appeared calm and relaxed.
- We heard how staff had facilitated an admission from theatre recovery to the unit for a patient suffering with a mental illness. The patient had previously been a patient on the unit therefore staff felt it was more appropriate to wake the patient in the unit surrounded by staff who they were familiar with rather than unfamiliar staff.

Understanding and involvement of patients and those close to them

- Patients and relatives we spoke with on all units told us they were involved and kept up to date with the care and treatment of the patient. They said the staff took time to make sure the patients and relatives understood the care and treatment and the options available.
- We saw in patient records where doctors had noted their discussions with relatives. The notes showed the questions asked by relatives and the answers given which was clear and specific to the individual patients.
- On the back of the patient name boards was a question, which stated 'what matters most to me today'. We observed nursing staff completing these with patients and or relatives. One patient wished to watch a specific television programme at a certain time. We noted the nurse ensured the patient had the television tuned to the correct channel at the specific time.
- We saw good interaction between a physiotherapist, patient and relative when explaining the rehabilitation needs of the patient.
- Patients who had been discharged from GICU were invited back at a later date with their relatives to share their experiences of intensive care. We saw a video had been recorded recently (August 2015) of patients sharing their experiences; this was used as part of ongoing development of the service. Because of feedback from a patient at the meeting, visiting times had been changed. Visiting times were made flexible to accommodate those patients' relatives who were unable to attend the unit at the hospitals standard visiting times.

Emotional support

- The hospital chaplain was available to visit the units regularly and on request to provide support.
- Patients discharged from critical care were followed up on the ward by staff from the critical care outreach team or an advanced nurse practitioner. This was to support the patient with their recovery and to support the ward staff to meet the patient's needs.
- The critical care outreach team assessed patients discharged from GICU using cognitive and trauma screening questions. This meant additional emotional and psychological support were offered, if required.
- We saw staff on all units providing reassurance for patients who were anxious. This included a nurse spending time with a patient, explaining what the patient should experience and how staff would help.
- Patients across all units told us staff were understanding, calm, reassuring and supportive and this helped them to be relaxed.
- During our inspection, we observed a specialist nurse for organ donation working closely with the critical care team in managing the sensitive issues relating to approaching a family to discuss the possibilities of organ donation. We later saw the support given emotionally to a donor's family.
- The units were not currently using patient diaries. Patient diaries are a simple but valuable tool in helping people come to terms with their critical illness experience. The diary is written for the patient by healthcare staff, family and friends. Research has shown patient diaries may help the patient better understand and make sense of their time in critical care and help to prevent depression, anxiety and post-traumatic stress. There were firm plans in place to roll this out across all critical care areas in January 2016.
- One patient on CICU told us when they felt frightened because they were unable to breathe, they said nursing staff were supportive, reassuring and made them feel at ease.
- A patient told us the unit had facilitated a volunteer (a previous patient) to attend the ward and chat to her about their experiences.
- A relative told us they were anxious in the middle of the night about their spouse and they persistently kept calling CICU. The relative said nothing was too much trouble and nurses provided good emotional support during every call. In the end, they told us nursing staff invited her to the hospital for more comfort.
- The Sheffield Critical care Support Group helped support patients and their relatives who had been

discharged from hospital following a stay on GICU/ GHDU. Patients and relatives were invited to attend a monthly 'drop in' session at a local venue to chat about their experiences and share their thoughts and feelings.

Are critical care services responsive?

Outstanding ☆

We found the responsiveness of this service to be outstanding because services were tailored to meet the needs of the individual patient. We found;

- There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met these needs. For example, we saw the use of distraction therapy and a special activities box for a patient living with dementia.
- There was an innovative approach to providing integrated patient centred care pathways. We saw where care of a patient with mental health needs had involved other services.
- Access to care was managed to take account of peoples need, including those with urgent needs.
- There was openness and transparency on how complaints and concerns were dealt with.
- Improvements were made to the quality of care as a result of complaints and concerns, this included staff working through examples of real complaints as part of their mandatory training.

Service planning and delivery to meet the needs of local people

- The CICU was a regional cardiothoracic unit and received referrals from a number of neighbouring hospitals.
- The critical care provision could be flexed to meet the differing needs of level two and three patients, for example, an increase in level three provisions if required.
- Follow up clinics were not provided for patients discharged from critical care. This does not meet the Core Standards for Intensive Care Units. Critically ill patients have been shown to have complex physical and psychological problems that can last for a long time following discharge from critical care. These patients benefit from the support offered by a specialised critical care follow up service once discharged. Although not a follow up clinic, patients were invited to attend the Sheffield Critical Care support group, which was led by the critical care outreach nurses. Nursing staff told us if a patient raised any concerns at these meetings, they would advise them to see their General Practitioner (GP).
- There were facilities for relatives to use such as a designated room. Relatives could stay overnight using recliner chairs in the patient's rooms if required.

Meeting people's individual needs

- Patients were reviewed in person by a consultant within 12 hours of their admission.
- Care plans demonstrated peoples' individual needs were taken into consideration before delivering care.
- Language interpreting services were available within the hospital if required. We saw there was access to a quick reference guide on one unit we visited.
- The units did not manage a significant number of patients living with dementia or learning disabilities but the nurses described how they would care for and manage such patients. They told us it was important to involve family members and carers in providing aspects of the care and support required.
- We saw there were facilities to cater for the needs for patients living with dementia for example a distraction therapy box, large bedside clocks and on one unit a special activities box.
- Nursing staff told us about the learning disability passport and the unit had a dementia link nurse who attended regular meetings and updated the team on any pertinent issues. Nursing staff were also encouraged to complete an e-learning module 'care of patients living with dementia'. Staff who had completed this said they had found it useful.
- Nursing staff also told us about the 'this is me' document, which they would encourage patients and relatives to bring into hospital during their stay. 'This is me'is a simple and practical tool people living with dementia can use to tell staff about their needs, preferences, likes, dislikes and interests.
- We saw there was chaperone policy in place. A chaperone is a person who accompanies a patient during an examination. For example, a female would be accompanied by a female member of staff when being examined by a male member of staff .Staff we spoke with told us every time a chaperone was required they assisted.

Critical care

- Post critical care patients had access to a psychologist if required; this was accessed through the critical care outreach team.
- We saw a nurse on CICU professionally challenging the decision of a doctor to wake a patient with known drug addiction. The nurse felt prior to the patient being woken sufficient medication should be administered. This would minimise any withdrawal symptoms and agitation the patient may encounter once awake.
- We were told by an Occupational Therapist application for funding had been made to purchase some head sensor call bells. These would give patients with restricted movement easier access to call bells, and a greater sense of independence.
- We saw plastic picture and word communication aids to help those patients who had difficulty expressing themselves.
- The units had access to a consultant psychiatrist for those patients who may experience mental health problems during their critical care stay.
- We saw in a set of medical notes a timely referral had been made to the mental health team when a patient with a long-standing mental health condition had exhibited signs of deterioration during their admission to the unit.
- We saw there was access to a garden on GICU; this had been equipped with the critical care patient in mind and included an electricity supply so patients on ventilators could use the facilities.

Access and flow

- In the reporting period December 2014 to November 2015, there were 1139 admissions to CICU, 1768 to GHDU and 801 to GICU.
- Eighty-nine percent of admissions to CICU and six% to GICU were planned.
- The decision to admit to critical care was made by an Intensive Care consultant together with the consultant or doctors already caring for the patient.
- A daily early morning round took place with the theatre Co-ordinator, Matron and CICU co-ordinator, ensuring theatres could start promptly and facilitating timely discharge of patients from CICU and the PCU to the wards. This helped to ensure the smooth flow of patients across the pathway.
- Critical care bed occupancy was in line with or below the England average for the period November 2014 to July 2015.
- Patients should be admitted to Critical care within four hours of the decision to admit. In the reporting period December 2014 to November 2015 96% of GICU and 100% of CICU admissions were meeting this target.
- The time of the decision to admit patients to the critical care was noted in all of the patients' records where it was required. In all of the records we looked at there was no delay in admitting the patient to the unit.
- Staff told us they avoided out of hours discharges whenever possible. ICNARC data from October 2014 to March 2015 showed the number of out of hour's discharges from GICU was similar to other units nationally. In the North Trent critical care network annual report 2014/2015 a higher number (34%) of patients were discharged out of hours from CICU. Discharges out of hours, for example at night, have been associated with an excess mortality and patients find it unpleasant to be moved from critical care to a ward outside of normal working hours.
- There was a higher rate of non-clinical transfers out of GICU when compared to those of similar units. (A non-clinical transfer is when patients are moved to a critical care unit in another hospital due to lack of beds. Clinical reasons would be for different specialist care, such as treatment for patients with severe burns). Current evidence and guidance indicates patients transferred to other critical care units for the same type and level of care spend longer in hospital overall and have poorer outcomes.
- There was a low rate of patients readmitted to GICU. A low rate of readmissions indicates patients were discharged at an appropriate point in their treatment and with suitable support.
- In the period January 2015 – September 2015 five patients were ventilated outside the Intensive Care Unit owing to bed pressures; this meant there may not be sufficient bed capacity.
- The average median length of stay in the reporting period 2014/2015 for GICU was approximately two days with a maximum stay of approximately 50 days. For CICU the median length of stay was approximately one day and maximum median stay of 94 days. The median is the "middle" of a sorted list of numbers.
- Patients should be discharged from the critical care within four hours of the decision to discharge. In the North Trent Critical Care, network annual report 2014/2015, 52% of patients on GICU / GHDU and 35% on CICU were discharged after more than four hours.

Critical care

- The North Trent critical care network annual report 2014/2015 reported the number of planned operations cancelled due to a lack of GHDU beds was 100; this was slightly higher than the previous years and significantly higher than the previous two years. Operations cancelled due to the lack of a CICU bed was not included in the report. There were plans in place to open additional beds on GICU and GHDU.
- We saw there was a specific critical care bed escalation policy which would be used if capacity was limited.

Learning from complaints and concerns

- There was a formal policy for managing concerns and complaints. Staff were aware of the policy and how to access it.
- Information on how to raise a concern or make a complaint was readily available to patients and relatives.
- There were low numbers of complaints about the critical care services. Complaints and concerns were discussed at monthly clinical governance meetings. Actions to address concerns and make improvements were noted. Most complaints related to communication between staff and relatives and lessons learnt were disseminated to staff.
- Real examples of complaints were used as part of mandatory training. Staff were expected to work through these examples, investigate and identify the reasons for the complaints and gain greater awareness and learn from them.
- We heard how new guidelines had been implemented following a complaint from a patient who had an extravasation injury. Extravasation is the accidental leakage of certain medicines into the body from an intravenous drip in the vein.
- Senior nurses told us they openly addressed any concerns or complaints raised in the unit and instantly enter into open discussions with patients and relatives in order to come to gain a quick resolution. Relatives we spoke to told us if they had a complaint, they felt confident they would be listened to and treated with dignity and respect during the process.

Are critical care services well-led?

Good

The leadership of critical care Service was good because leaders prioritised safe, high quality person-centred care. We found;

- There was a clear statement of vision and values, driven by quality and safety.
- There was an effective and comprehensive process in place to identify, understand and address current and future risks.
- There was a strong focus on continuous learning and improvement.
- The services proactively engaged and involved staff and ensured that the voices of all staff were heard and acted on.
- Staff innovation was supported.
- There was a high level of staff satisfaction.

However;

- Not all leaders had the necessary experience in critical care.

Vision and strategy for this service

- We saw copies of the care group's five-year strategy. The strategy for the Operating Services Critical care and Anaesthesia and South Yorkshire Regional Services care groups directorates were similar in that they were striving for the best clinical outcomes for patients and delivering patient centred care. These were in line with the overall hospital trust aims.
- Staff were able to articulate the trust's vision and the values, which were Patient first, Respectful, Ownership, Unity and Deliver forming the acronym 'PROUD'.
- We observed staff delivering care and demonstrating behaviours in line with the hospital values.
- We saw specific departmental vision which staff were working towards.

Governance, risk management and quality measurement

- There was a strong culture of clinical governance supported by multiple audits. There was a clear management structure, with teams working together effectively to provide an excellent service.

- There was a good feedback loop from governance meetings, which included monthly governance newsletters highlighting learning from incidents. This was seen in most staff areas and staff told us they also received it electronically, but we did hear some staff had difficulty accessing computers.
- There was an open invite to all MDT members at the monthly governance and mortality and morbidity meetings. Staff were encouraged to present any updates at these meetings
- Significant incidents and action points from clinical governance meetings and mortality and morbidity meeting were included as action points, which were read out at a daily five to five brief on GICU /GHDU.
- This five -five brief was written by nursing and medical team members across all units and had been set up so the leadership team could inform as many people as possible useful and important information in a consistent manner. Nursing staff told us the brief altered each week to provide the latest relevant information and updates. Staff had the opportunity to contribute to the five to five briefing as and when they had useful information to share across the whole team. The briefing supported effective and consistent communication across the team. In all of the meetings, we attended during our inspection, for example, daily handovers and ward rounds we saw the five to five brief was read out aloud to all of the team members present.
- Communication in other areas was a combination of email, newsletters, staff meetings and notice boards.
- There were monthly and bi monthly work streams for catheter related blood stream infections (CRBSI) and Ventilator Acquired Pneumonia (VAP) to review compliance with the associated care bundles**.**
- Appropriate risk registers were maintained reviewed and acted upon; risks with a significant rating were escalated to the executive team for oversight and consideration. Unit leaders told us of the current risks affecting the units.
- The services measured themselves against both the Intensive Care Society Core standards and the North Trent Critical care Network service specifications. Peer reviews were carried out, however in 2014 and 2015 a peer review was not carried out and instead a critical care network audit was carried out. We reviewed minutes from the North Trent Critical Care Operational Delivery Network meeting and noted that there were plans in place to facilitate peer reviews going forward.
- CICU did not demonstrate continuous patient data contributions to the Intensive Care National Audit and Research Centre (ICNARC). This meant the care delivered and mortality outcomes for patients were not benchmarked against similar units nationally.
- We saw minutes from clinical management group meetings, agenda items included clinical guidelines, learning from incidents and governance. Items and actions were discussed with the unit teams.

Leadership of service

- The senior leadership team consisted of a Clinical Director, Nurse and Deputy Nurse Director, Operations and Deputy Operations Director and Clinical Leads.
- There was clear nursing and medical leadership with the integrity, capacity and capability to lead the service effectively.
- The local nursing leadership in some areas did not meet the Core Standards for Intensive Care Units. The lead nurse with overall responsibility for the nursing elements of the service should be an experienced critical care nurse in possession of a post-registration award in critical care nursing. The interim matron, although an experienced nurse and manager, did not have the relevant critical care experience or qualification.
- We saw senior medical and nurse leaders were committed to providing a safe service for their patients.
- The organisational chart for the critical care showed nurses were in specific lead roles such as quality and audit, practice education and rehabilitation and were therefore able to influence nursing care delivery within the units.
- Ward managers were supported by the trust to complete a nationally recognised leadership programme.

Culture within the service

- Most staff were positive about working at the hospital, they felt listened to and valued. They said patients and staff knew if they raised an issue, it would be taken seriously.
- Some nurses told us they were often moved to other wards where there were gaps in staffing and said they accepted the need for this sometimes but felt frustrated at being moved. Senior and junior nursing staff told us this had caused low staff morale.

Critical care

- We found a supportive and open culture, with nursing, multi-disciplinary and medical staff.
- Staff told us they felt able to raise concerns about incidents poor care and safeguarding.
- Staff told us senior nurses, matrons, consultants were visible, supportive, and staff felt happy to discuss any issues.
- Staff told us they were most proud of the teamwork and the willingness to help and support each other.
- We were told of an example where a member of staff had required additional support and assistance in their personal lives in order to remain at work and carry out their job. The extent of the support provided to the staff member showed a positive regard for their welfare.

Public engagement

- Thank you cards from patients and relatives were displayed.
- On CICU patients were invited to attend a support group on discharge.
- We saw examples where other units had invited past patients in who were now volunteers to sit and talk with current patients

Staff engagement

- Through the use of a hospital initiative 'Listening Into Action', staff within the hospital were actively encourage to explore the experiences of patients and carers and work together as team to look at ways of improving patient care and experiences. This was then presented to the executive team to progress to the next stage. The initiative is still in its infancy and staff were unable to give us any examples of change at the time of our inspection.
- We heard how 'Big Breakfast' and 'Afternoon Tea' events had been created in the local departments. These were for all staff to attend and discuss any concerns, ideas and talk with the senior leaders in the directorate and hospital.
- We saw you said we did boards in some staff rooms, which allowed staff to see their voices were heard.

Innovation, improvement and sustainability

- On GICU and GHDU there was the use of an electronic patient information system to ensure timely and accurate records, access to trust and local policies, procedures and guidelines.
- An advanced clinical pharmacy service had been developed to improve the safety and efficacy of medicines used in GICU and GHDU.
- The use of the Enhanced Recovery After Thoracic Surgery (ERAS) programme had resulted in marked improvements in the quality of care for patients on CICU.
- We saw an Occupational Therapist (OT) had been funded to work two and a half days per week on GICU. This was a new role and the OT we spoke said they were scoping the role in order to create a patient centred OT services for critical care patients.

End of life care

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

Information about the service

End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It is delivered by a multidisciplinary team and includes aspects of essential nursing care, medical and therapy interventions specialist palliative care, bereavement support and mortuary services. All these services were involved in end of life care at Northern General Hospital.

The hospital was the largest campus within Sheffield Teaching Hospitals NHS Foundation Trust. It had over 1100 beds and employed more than 6,000 staff.

In 2014 to 2015 there were 2239 deaths at Northern General Hospital; 755 of these were known end of life care patients. The number of end of life care deaths in hospital increased during 2014- 2015 by 14% from the year before. At the same time there had been an increase in referrals to the specialist palliative care team. The increase in referrals accounted for the increase in the number of deaths under the care of the end of life service.

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

There were 18 dedicated end of life care beds situated on the Macmillan palliative care unit. This ward provided 24 hour care in a separate building on the hospital site.

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

As part of our inspection, we specifically observed end of life care and treatment on wards and other clinical areas. We looked at 29 sets of patient care records, including medical notes, nursing notes and medicine charts. We visited the bereavement service, multi-faith centre, mortuary, emergency department (ED), and Macmillan palliative care unit. We spoke with 53 staff including ward nurses, the patient's bereavement officer, the mortuary team, doctors, porters, chaplains, the SPCT, pharmacists, end of life care facilitators, complimentary therapists, allied health professionals and senior managers. We also spoke with five relatives and two patients who were receiving care. Before our inspection, we reviewed performance information from, and about the trust.

End of life care

Summary of findings

We rated end of life care services as requires improvement. We rated safe, caring and responsive as good, however we rated effective and well led as requires improvement.

We found;

- Do not attempt cardiopulmonary resuscitation (DNACPR) decisions were not always made in line with national guidance and legislation, for example the Human Rights Act (1998) and the Equality Act (2010).
- The Deprivation of Liberty Safeguards (DoLS) policy expired in October 2013. The flowchart to guide staff in DoLS decisions was also out of date. DoLS were not used on the Macmillan palliative care unit although the trust had sought advice regarding this.
- The trust did not monitor if patient choice around preferred place of care or death was met.
- There was no internal strategy in place for end of life care at the trust. We could not ascertain how progress towards achieving the five year plans leading up to 2017 was measured.
- There was limited monitoring of quality of care for end of life care
- In response to the 2013 review of the Liverpool Care pathway, the trust withdrew the pathway and trained staff in the 'five priorities of care' as described in national guidance. Local guidance was not introduced until October 2015,

However, we also found:

- Patients received safe care and treatment which met their needs. The specialist palliative care team of nurses and doctors were skilled and knowledgeable. They were experienced in providing support to patients and families and training to other staff.
- There was a specialist palliative care unit staffed by a skilled team. Care was led by consultants and a range of staff responded to patient needs. The specialist palliative care team supported other wards in the hospital.
- In the year from April 2014 to April 2015, over 97% patients were seen within 24 hours of referral to the specialist palliative care team. There was seven day cover from the team.
- There was evidence of compassionate and understanding care on all the wards at the hospital. Staff we spoke with understood the impact of end of life care on the patients and family well-being.
- There were positive examples of local leadership on the Macmillan Palliative Care Unit (MCPU) and in the palliative care team from both a nursing and medical perspective.
- There were areas where there was potential for improvement and these had been identified by the trust. We saw evidence that work was in progress to further improve the service.

End of life care

Are end of life care services safe?

Good

We rated safe as good because;

- Appropriate action was taken if an incident happened. Staff learned from previous incidents.
- Infection prevention and control measures were in place on the Macmillan palliative care unit and audit results were consistently good.
- There was a well-staffed specialist palliative care team which provided seven day cover.
- Records were mostly completed appropriately and risks were identified.

However we also found;

- No one took responsibility for cleaning the concealment trolley used to transport deceased patients to the mortuary.

Incidents

- The trust had an electronic reporting system for incidents. We found that staff were aware of this and how to report incidents.
- There had been 129 incidents on the Macmillan palliative care unit (MPCU) between September 2014 and August 2015. Of these, 63 had been slips, trips or falls. One fall had resulted in a fracture. Investigations by the trust found this was not reportable as a 'RIDDOR'. RIDDOR is the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations-2013.
- There had been 34 pressure ulcers reported and 13 drug related incidents. Other incidents were related to general care.
- We saw that appropriate action had been taken for all the recorded incidents. We spoke with senior staff on the unit; they said there was a high rate of reporting.
- They told us the pressure ulcers had been found to be non-attributable to the unit. Patient's skin was checked and photographed if necessary on admission. Incident forms were completed if there were delays in the delivery of drugs to the unit and this accounted for "most" of the incident reports. One incident had resulted in delayed treatment for a patient, for all others no harm resulted.
- We also spoke with the MCPU pharmacist; they had not been aware of the incident reports related to drugs.
- We saw that all incidents were discussed at the MPCU team meetings and a weekly bulletin was printed and displayed in the staff room so staff may learn from previous incidents.

Duty of Candour

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

Safety thermometer

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care.
- The senior nurse on the MPCU told us they had designated time to carry out audits and submit information for the safety thermometer. We saw data from August 2015 to January 2016. In September 2015, the result of harm free care was 62.5%. This improved to 79% in November 2015, but reduced again to 65% in December 2015.
- This suggested the unit did not always deliver harm free care; however this was affected by the high number of patients who were admitted to the unit with existing pressure damage. We saw that the level of 'all' recorded pressure ulcers was 25% over several months in 2015. 'New' pressure ulcers (those which developed on the unit) were low at less than 5% on average.
- Results were fed into an electronic clinical assurance tool known as 'eCAT' where they were stored and could be compared over time.

Cleanliness, infection control and hygiene

- The MPCU looked clean and tidy when we visited.
- We were shown results from infection prevention and control audits on the MPCU; 100% had been achieved consistently. The housekeepers on the unit were part of the ward team and were managed by the senior nurse. The housekeeper carried out a monthly environmental audit.

End of life care

- There was a trust wide infection prevention and control policy related to the care of deceased patients. This provided clear guidance for staff.
- We saw that staff used personal protective equipment and were bare below the elbows. There was access to hand-washing facilities.
- It was trust policy that all deceased patients were placed in a sealed body bag before being taken to the mortuary. Mortuary staff told us this meant nurses did not have to risk assess infection risk on the ward after someone died.
- Areas inside the mortuary fridges were deep cleaned twice a year as recommended by the Human Tissue Authority.
- We were shown results of a mortuary cleaning audit from August and September 2015. In August 97.8% was achieved; in September this improved to 98.9%.
- No one appeared to be responsible for cleaning the concealment trolley used to transport deceased patients to the mortuary. It was stored in the mortuary and porters collected and returned it there each time it was needed. Mortuary staff told us it was not their responsibility to clean the trolley, as did the porters. After our inspection, senior staff told us they had developed a standard procedure and cleaning log to ensure the trolley was cleaned by the porters.

Environment and equipment

- The MPCU looked clean and tidy when we visited. Deliveries of stocks and linen were quickly tidied into designated storage areas.
- There was a locked cupboard inside a storage room where cleaning and caustic materials were safely stored.
- There was a ceiling track hoist in each side room on the MCPU to free up floor space.
- McKinley syringe pumps were in use on the wards. Staff told us these were obtained for use from the medical device library and there were no delays in obtaining them when needed. The site manager obtained them for ward staff outside of standard working hours. The syringe pumps were maintained by clinical engineering staff.
- We were shown maintenance schedules which indicated 89% of pumps were maintained within one month of the due date. This was against a target of 90% for high priority equipment such as syringe pumps.
- Underfloor heating was installed throughout the MPCU. This had made the clinic / medicines room very warm. The air temperature was 26 degrees when we visited. Staff had reported this as a risk because the high temperatures could affect the drugs fridge. Work was due to take place to isolate the heating for that area of the building.
- The bathroom had an electrically operated Jacuzzi bath which was awaiting repair as it was cracked. Staff told us it had been reported two weeks previously. There was a stretcher hoist for the bath which could be used for patients who were not able to sit upright.
- There was a cooled room for viewing deceased patients towards the rear of the building. Family and friends could stay with deceased patients in this area which was sensitively decorated and furnished. Deceased patients were taken from this area out via a back door to the designated mortuary ambulance so they did not have to pass other patient areas on the unit.
- The concealment trolley was designed and intended for indoor use only, however it was used outside on the hospital roads. This meant it became dirty and wet and the wheels became damaged by ruts in the roads.
- We were shown a mattress store and a new 'lo-lo' bed. This bed had been purchased using donations; it could be lowered to just a few inches above floor level for patients who were at risk of falling from or climbing out of bed.
- Staff told us it could take up to three days for a specialist pressure relieving mattress to be delivered from the equipment library. This meant patients could have to wait for the right mattress for their needs. If this happened it would put them at risk of developing pressure damage to their skin.
- We were shown plans to extend and rebuild part of the unit. This was due to be funded totally by charitable donations. Staff had been consulted in the design of the new building which would have purpose built areas for patients and their families. The building work was due to commence around autumn time of 2016.
- We visited the end of life room in the emergency department. This was used if someone was imminently dying and where relatives could wait with a deceased patient. The room was basic, but clean and sensitively decorated. There was a flower symbol on the door to indicate to staff when the room was in use and avoid disturbances.

End of life care

- There was a security system at entry to the mortuary and closed circuit television was in use in all areas. This included the 'garage' area for funeral directors cars.
- The fridge doors were linked to an alarm system. The temperature recording system was calibrated so in the event of a fault or temperature dropped an alarm sounded both in the mortuary and on the main switchboard; the estates team would then respond.
- Mortuary staff told us they had passed routine inspections carried out by the Health and Safety Executive and the Human Tissue Authority in 2014.
- There was capacity for 65 deceased patients in the mortuary fridges. The top and bottom shelves were rarely used as the top shelf was very high and the bottom one was very low; this had been assessed as being a handling risk to mortuary staff and porters. Staff told us there was still enough room for deceased patients.
- There were no individual closed fridge spaces for deceased bariatric patients, however there was designated racking in the body store. When this and the other external racking was in use the mortuary was cooled to accommodate these patients, if required.
- There was a post mortem area and viewing gallery where students or other staff could observe post mortems, although most were now carried out off site.

Medicines

- There were large stock levels of appropriate medicines on the MPCU. There was a clear process of checking controlled drugs and we saw clear documentation of drug wastage and disposal.
- Two medicine trolleys were in use on the MPCU. Individual drawers were designated for each patient, and the drawer was taken to the bedside to administer the drugs. The aim was to reduce drug errors as staff would be less distracted.
- Intravenous fluids were stored in a locked room along with portable oxygen cylinders. There was a portable suction machine as wall mounted suction was not installed in the bays.
- The unit had its own pharmacist and pharmacy technician. They reviewed medicine charts and supported the process of making sure patients were taking appropriate and necessary medications.
- There was an above average spend of medicines on the MPCU. There was high usage of medications which had been imported. Senior doctors told us usage of these drugs was a regional or personal preference of doctors.
- The specialist palliative care team gave advice on medication to ward doctors and nurses. There was 'Guidance for Medicines Management of Hospital Patients in the Last Few Days of Life'. This was part of the pilot document 'Guidance for the care of the person who may be in the last hours to days of life'.
- Where appropriate, current medication was assessed and non-essential medication discontinued. Patients were prescribed anticipatory medications. The aim of anticipatory prescribing is to ensure in the last hours or days of life there was no delay in responding to a patient's symptoms.
- The trust had a multiagency palliative care formulary in place.

Records

- An electronic records system had been recently introduced at the trust. Staff told us there had been some setbacks in its use which senior managers were aware of.
- We checked records on the MCPU to see how individual needs were met. Care 'rounds' took place every two hours. We found most records were completed.
- There were both paper and electronic records in use across most areas of the hospital. We saw that paper records were stored securely, and the electronic boards on display were used in a way to maintain confidentiality.
- A Sheffield palliative care coordinating system project (SPaCCS) had been developed and was being piloted.

Mandatory training

- An electronic system was in use to monitor and manage mandatory training. Information was transferred from electronic staff records into the Personal Achievement and Learning Management System (PALMS).
- There were training leads and administrators who kept records up to date.
- All the mortuary staff were up to date with their mandatory training; compliance was 100%.
- There was variability in compliance with mandatory training for porters; the overall compliance was over 93% which was above the trust target of 90%

- On the MPCU, overall compliance was 80%; we saw that this had been affected by long term sickness.
- The specialist palliative care team had variable compliance with mandatory training. Of the 12 topics included in mandatory training, two had been achieved to be near or above the trust target. Overall compliance was 79%.

Assessing and responding to patient risk

- We saw risk assessments completed in medical and nursing records. These were commenced on admission and there was evidence that risk assessment continued throughout the patients stay in hospital. Examples of this included skin assessments for pressure ulcer risk.
- An early warning tool, SHEWS (Sheffield hospitals early warning score) was used to monitor for patient deterioration. This was a scoring system in which a score was allocated to physical measurements such as blood pressure and respiratory rate.
- We checked SHEWS charts on the Macmillan palliative care unit. Most records were appropriately completed, however one chart indicated the SHEWS had not been recorded for four days when the score was 3 and was escalated to a trained nurse. There were no documented records to indicate why the SHEWS was not recorded after this.
- Clinical nursing guidelines had been developed for end of life patients. Once it was decided someone was nearing the end of life and had increased needs, nurses could refer to the guidelines on the intranet. This process however, was reliant on the individual nurses skills and experience; there were no 'triggers' or formal pathway to support the decision making.

Nursing staffing

- The specialist palliative care team had a clinical and educational role and the clinical nurse specialists worked seven days a week. There were 7.6 WTE (whole time equivalent) clinical nurse specialists (plus 1 WTE vacancy). A new team member was due to start working with the team in January 2016. There were a minimum of two staff at Northern General on weekdays and one on a weekend.
- The team had moved to seven day working without an increase in staffing. This meant the number of staff on during the week was reduced in order to cover weekends.
- They covered three hospitals at the trust. The teams were based on the Macmillan palliative care unit at the Northern general hospital site and at the Royal Hallamshire hospital
- There was a team of nurses on the MPCU. They had slightly more than full establishment in August 2015; this meant they were fully staffed with 22.7 WTE actual registered nurses in post. The plan was for 22 WTE nurses.
- The Band 7 charge nurse was due to leave the unit as the end of our inspection week. They had been redeployed to cover another ward for a year. Interviews were due to take place to replace them.
- There were 9.5 health care support workers in post, against a planned establishment of 9.6 WTE.
- There were 18 beds on the MPCU and the high dependency of the patients meant the ratio of nurses to patents was greater than on 'standard' wards. The shift plans were for:-
- Early shift -five registered nurses, plus two heath care support workers
- Late shift - four registered nurses, plus two support workers
- Night shift- three registered nurses, plus one support worker.
- This gave a ratio of one nurse to 3.6 patients on an early shift, one nurse to 4.5 patients on a late, and one nurse to six patients on a night shift. This was better than the minimum recommended by the safer staffing tool.
- Senior nurses from the MPCU were working with the local hospice to develop an acuity tool to determine optimal staffing levels. We could not ascertain when this would be in use.
- Registered nurses had been required to move wards and work in other parts of the hospital during the day and night. This had happened due to low numbers of nurses working in other areas. Senior staff told us risk assessments were in place and patients' needs were considered before staff were moved to other areas.
- There was funding for 1.6 WTE end of life care facilitators who worked across the trust and also provided training support to community nurses and care home staff. One permanent staff member worked two days a week and another was seconded into a three day post. There were

End of life care

73 end life care 'champions' or nominated link nurses across the trust. Their role was to raise awareness of good end of life care and to promote best practice on the wards.

Medical staffing

- The palliative care doctors comprised of 4.6 WTE consultants and 6 WTE specialist registrars. They covered all areas of the trust. Information from the trust indicated there was a low vacancy rate of 0.2 WTE (less than 1%).
- The medical staffing levels were in line with the minimum requirement for the local population (Commissioning Guidance, National Council for Palliative Care 2012).
- Junior doctors told us they felt supported and the consultants were very 'hands on'. The on call rota could be busy for junior doctors, however consultants filled the gaps. This meant there was less need for temporary doctors.
- There was low usage (2.2%) of locum or temporary doctors from April 2014 to January 2015. This means there was continuity of medical cover which helped to keep patients safe.
- The core working hours of the palliative care doctors was 9am- 5pm Monday to Friday. Some consultants finished at 6 pm on certain week days.
- There was 24 hour cover from a palliative care consultant and registrar on an on –call basis. The on call duties included face to face medical care and telephone advice.
- The senior medical staff on call provided cover to wards in the trust, the local hospice and another hospice in Chesterfield.
- Senior doctors also supported some primary care and community services across Sheffield when specialist advice was needed.

Other staffing

- There were five mortuary staff who worked across the trust. They included a mortuary manager, a senior technician, two technicians and an assistant technician.
- There was a team of porters who worked across the trust. Approximately 10 porters were involved in end of life care. They were responsible for handling deceased patients and transferring them to the hospital mortuary via the ambulance or concealment trolley.

Major incident awareness and training

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

Are end of life care services effective?

Requires improvement

We rated effectiveness of end of life care services to require improvement because:

- There was variable compliance with national standards for completion of DNACPR forms (do not attempt cardiopulmonary resuscitation).
- There was no individualised care pathway to help staff identify and care for end of life patients. Standardised nursing care guidelines were available as a reference tool and staff could print these to use as a guide. However, there was no way to ensure all the relevant guidelines were followed and acted upon.
- The results from the National Care of the Dying Audit (2014) showed two out of seven organisational indicators and three out of 10 clinical indicators had been achieved. The trust had taken action against the results of the National care of the dying audit for hospitals (2014) to improve the delivery of end of life care and had participated in the 2015 audit.
- The Deprivation of Liberty Safeguards (DoLS) policy and flowchart was overdue a review from October 2013.

However, we also found:

- Patients' care and treatment was planned in line with current evidence based guidance, standards and best practice legislation.

End of life care

- The number of referrals to the specialist palliative care team increased from 2014 to 2015. The number of non-cancer patients seen by the team had also increased. This meant the team had worked with other services to reach patients with other conditions.
- Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. They were supported to maintain and further develop their professional skills and experience.
- Pain relief for end of life patients was a priority and records demonstrated this.
- Staff worked well together to understand and meet the range of people's needs.

Evidence-based care and treatment

- In response to the 2013 review of the Liverpool Care pathway, the trust had produced guidance for staff. The pilot document 'Guidance for the care of the person who may be in the last hours to days of life' was based on up to date evidence and national guidelines. These included guidance from;
- the Leadership Alliance for the Care of Dying People (2014),
- More Care, Less Pathway: An Independent Review of the Liverpool Care Pathway (2013)
- Palliative and end of life care for Black, Asian and Minority Ethnic groups in the UK, Public Health England (2013)
- The guidance was intended to ensure patients were appropriately assessed and supported with their end of life needs and included flowcharts and management plans. There was no tool or pathway for staff to complete.
- The guidance had recently been issued in (October 2015), so its effectiveness had not been measured. It was too early to say if this would impact on effective care and treatment.
- When it was decided a patient was for end of life care, nurses could refer to nursing care guidelines on the intranet. This meant they could follow procedures of what nursing action to take.

Nutrition and hydration

- We saw on the MCPU that patient's food and drink needs were assessed and met. There was a kitchen were food from the main hospital was heated. The trolley was kept in the kitchen area so patients who did not feel like eating were not affected by food smells.
- Special diets and food supplements were noted on a white board so support staff could ensure patients had prescribed supplements.
- We saw there were nursing care guidelines on the intranet related to nutrition and hydration so nurses could follow these. There were examples in patient records where the guidelines had been used.
- There was a fridge on the MCPU specifically for patients own food and drink. Families could leave things for their loved ones to have when they wanted them.
- Staff told us patient could have their breakfast when they wanted on MCPU, there was no set time. A variety of cooked breakfasts, porridge and cereal was prepared individually when patients wanted it.
- There was a drinks machine were family and friends of patients could obtain free hot drinks.

Pain relief

- Symptom management guidance, including pain relief, had been produced by the specialist palliative care team. This was available on the trust intranet and within the 'guidance for the care of the person who may be in the last hours to days of life'.
- There were key prescribing points for staff to follow related to pain relief and to ensure medicines were available when the patient needed them.
- We saw records on the MCPU which showed severity of pain, site and type of pain were recorded, and that pain relief was offered.
- We checked pain charts on surgical wards, they were all appropriately completed.

Patient outcomes

- The results from the National Care of the Dying Audit (2014) showed two out of seven organisational (KPIs) were achieved; these included access to specialist support for care in the last hours or days of life and clinical protocols for the prescription of medications at the end of life. Five out of seven were not achieved; these were access to information related to death or

dying; care of the dying education, training and audit; trust board representation and planning; protocols to promote dignity and respect; formal feedback processes for bereaved relatives or friends.

- In the 2015 National Care of the Dying Audit, the categories changed however just three out of eight organisational quality indicators were achieved. This meant there had not been significant organisational improvement.
- For clinical KPIs, the hospital did not achieve seven out of 10 indicators in the 2014 audit. These included recognition the person was dying, communication regarding the plan of care, and a review of food and drink requirements. Three clinical indicators were better than the England average. These were- medication prescribed for when it might be needed; a review of the number of necessary assessments in someone's last 24 hours of life; a review of care after death.
- In response to the performance results of the National Care of the Dying Audit, a project team developed an action plan with 10 recommendations. These included plans for a seven day face to face specialist palliative care service, an annual audit of care of the dying and the development of nursing guidance. The trust reported these had all been completed by May 2015. The hospital results for multidisciplinary recognition that the patient was dying were much lower than national average of 59%, at 40%. In response to this, a communication framework was developed for initial and on-going discussion.
- There was one action which had not been achieved. This was education and training in care of the dying for all staff that care for those patients. A training needs analysis was undertaken and discussed with the strategy group. The trust action plan showed further funding was obtained and a training plan was in development.
- The more recent results in the 2015 national care of the dying audit were not directly comparable; however they showed the trust achieved just two out of five clinical outcomes. They were significantly worse (30% compared to 66% nationally) for the percentage of patients in the last 24 hours of life having an individual plan of care and holistic assessment of the patient's needs. There were better than average results (74% compared to 56% nationally) for documented evidence for the needs of the person important to the patient being asked about.
- An audit of medications used in the last 72 hours of life was carried out in 2015. Results showed 100% overall compliance with trust standards on the MPCU. There was 87.5% compliance in the rest of the hospital (NGH), although this was a small sample of 10 patients. Recommendations included anticipatory medications forming part of the 'last days of life care guidance'.
- There was a plan for 2016 to collect and monitor information about patient outcomes. Topics included a service review of the use of ketamine in palliative medicine, a review of complaints and looking at why patients known to the palliative care service attend accident and emergency.
- There was also a plan to review the use of the AMBER care bundle (Assessment, Management, Best practice, Engagement, Recovery uncertain) on Ward Brearley 7.
- The trust was developing an electronic system, a 'clinical information portal'. The aim was to link this to another electronic method, so that end of life patients could be identified if they were admitted to hospital. These meant the specialist palliative care team could be informed about their admission and see the patient quickly.

Competent staff

- We saw that the porters had the right skills and experience when dealing with end of life or deceased patients.
- A small number of porters had extra training to drive the ambulance used in deceased patient transfers to mortuary and in handling deceased patients.
- Two porters told they had undertaken patient experience training. Two other porters told us there was a lack of opportunity to develop new skills.
- We met two mortuary staff at the hospital. They were experienced in support of bereaved families. They told us there was no specific training which encompasses dignity and customer experience available. They said they had learned from mentorship, direct observation and peer to peer feedback in order to gain knowledge and skills to help bereaved families.
- Mortuary staff had been trained to carry out post mortem examinations; however most post mortems now took place at other facilities which were not part of the hospital.
- We met one skilled and experienced nurse who was the end of life care facilitator. They were responsible for the

training plan for different staff groups in the trust. They showed us the training schedule for 2016/ 2017. The programme included training for staff about care of the dying and the five priorities for care.

- There was a plan to teach staff on a diabetes ward about advanced care planning and asking patients about their preferred place of care.
- End of life care training was given to apprentice staff and support workers in order to develop their skills in giving essential care.
- 'SAGE & THYME' ® training was part of the 2016 plan. Consultants and other staff had been involved in delivering this training to staff for the last two years. (The SAGE & THYME ® model was developed by South Manchester NHS Foundation Trust. Its purpose was an aide-mémoire to train all grades of staff on how to listen and respond to patients or carers who were distressed or concerned).
- The specialist palliative care team of nurses and doctors were skilled and knowledgeable. They were experienced in providing support and training to other staff. Most of the team had worked at the trust for several years and they were an established team who had a good reputation throughout the trust.
- All of the nurses were non-medical prescribers. This meant they were trained to prescribe certain medicines for end of life patients.
- They told us further education and degree courses they had undertaken was paid for by Macmillan.
- The specialist nurses started as a band 6 when they joined the team and progressed to a band 7 senior post once they had fulfilled competencies.
- The specialist palliative care nurses had group supervision with a psychologist. This meant they were able to reflect on and review their practice. They could identify training and development needs.
- The nurses had other roles which supported the learning in the team. For example one specialist nurse was the 'link' for governance (the system in the NHS which looks at improving services).
- The specialist palliative care registrars met for half a day each week for education and training.
- There were 73 care champions across the trust. They had an interest in improving care and support for people at the end of their life. They attended 'champions days' each year in order to share idea and learn from each other.
- Staff on four wards at Northern General Hospital had been trained to use the AMBER care bundle (Assessment, Management, Best practice, Engagement, Recovery uncertain).
- The end of life care facilitator delivered initial training to staff on those wards. A consultant on one of the care of elderly wards told us there had been no subsequent training and the principles were no longer embedded on the ward. This meant that new staff may not be able to follow the values.
- Senior staff on three wards, (two surgical, and one medical ward) told us they were not aware of the end of life care guidelines which had been recently launched.
- We were concerned that on one of the surgical wards, staff told us they continued to use the Liverpool Care Pathway (LCP) as a reference guide to help them care for patients.
- The trust target for appraisals was 95%. There was 100% compliance with annual appraisals on the Macmillan palliative care unit (MCPU). This was above the trust average of 88% (in November 2015). This meant all staff performance and development was discussed and monitored.
- Band 6 and 7 senior nurses appraised staff nurses; band 5 staff nurses appraised the housekeepers and ward clerk.
- There was a revalidation information notice board in the staff room on the MCPU. There was a plan to link revalidation to performance to ensure nurses remained fit to practise in line with the requirements of professional registration, throughout their career.
- There were 'link' nurses on the MCPU. They were interested in and assigned a variety of nursing topics such as bereavement, infection prevention and documentation. They had additional roles of updating colleagues on these subjects.
- There had been use of the trust Microsystem Coaching Academy on the unit. This meant staff had worked with coaches in improvement methods. Staff told us it helped them think differently about problems. Nurses on the MCPU were working on a project to improve the ward handover sheet.
- Student nurses were allocated to the MCPU. They were based there for up to a year as a 'base ward. Team mentorship was in use, this meant each student had a sign off mentor for competencies, and there was a team approach to their learning and development.

End of life care

Multidisciplinary working

- We saw positive internal multidisciplinary team (MDT) working between all staff we came across. This included including ward nurses and doctors, the specialist palliative care team, therapy staff, the bereavement officers, mortuary staff, pharmacists, porters and chaplains. Volunteer staff worked with professionals for the benefit of patients.
- There was a weekly MDT meeting on the MCPU and daily MDT handovers. This meant all staff were aware of plans for the patients.
- Physiotherapy and Occupational therapy staff were part of the MDT on the MCPU. They were allocated to work there on a six monthly basis and supported practical involvement for patients reaching the end of life as well as the support needed for their families.
- We saw interactive discussions between clinical nurse specialists and ward nurses on the respiratory ward.
- The 'transfer of care' nurses worked with ward nurses when arranging discharge or transfer from hospital.
- Staff told us of external MDT working with the 'Intensive nursing at home' team and community staff who were involved in end of life care.
- The palliative care consultants were part of the NHS Sheffield end of life care planning and commissioning network and worked together with hospice staff for the benefit of patients.
- There was no use of a standard EPaCCS (electronic palliative care co-ordination system). This is a tool to allow professionals to share information about a person's care preferences across different organisations. A Sheffield Palliative Care Coordination System (SPaCCS) which was in development and being led by the local hospice; when implemented, this would enable MDT working across organisations.
- This was developed as a result of an end of life communication audit (January to July 2014). The trust found a poor record of communication of relevant information to primary care (GPs) and a "Failure of patient care pathways to connect" to each other.
- There are significantly higher cancer death rates in Sheffield than the England average. There are also significantly higher hospital death rates and lower care home and home death rate than England average (End of life care intelligence July 2015).
- This meant more cancer patients died in hospital so it was very important for hospital teams to work together with community teams when passing on information about patients.

Seven-day services

- The clinical nurse specialists in the palliative care team worked across seven days a week from 9am – 5pm.
- One of the team preferred weekends and so worked in agreement with the team and their manager. The other specialist nurses worked one weekend out of four.
- There was a consultant and specialist registrar available 24 hours a day. They were based on the MCPU. They worked from a rota to cover out of hours.

Junior doctors worked from 9am – 3pm on weekends and bank holidays.

- Mortuary staff had a 24 hour, 365 days a year cover. The manager told us they were on call on a year round basis. They had been contacted several times for advice while on holiday. Out of hours, the duty manager would meet bereaved families at hospital reception and accompany them to the mortuary.

Access to information

- There were different IT (Information technology) systems in use in different areas. Not all teams of staff could access information added by other teams. This meant that all the information needed for patient care could not always be shared in a timely way.
- Staff told us they copied information from SystmOne, (another electronic process) onto Info-flex. Info-flex could be viewed by hospice staff, community palliative care team, GPs, out of hours GPs and district nurses. However, they could not enter information onto the system.
- Complex care managers (who were involved with hospital discharge of patients with complex needs) used SystmOne, which could be viewed by GPs and community out of hour's teams.
- Information from a system known as ICE (Integrated clinical environment) was used to write discharge information onto an electronic letter in the 'e- discharge' system. This was sent to GPs and printed out to give to community nurses when patients were discharged. This meant information about end of life care needs was passed to community teams.

End of life care

- Specialist palliative care consultants also used dictaphones in addition to writing in patient notes. This recorded information was typed by admin staff and sent to GPs.
- A new system, the Sheffield Palliative Care Coordination System (SPaCCS) was in development. We could not ascertain if this would be a system which all relevant teams could access
- A further electronic system had been implemented shortly before our inspection. There was a period of transition, so both paper and electronic records were in use. Four staff told us this meant it took them much longer to record patient information in two places.
- Information from the trust showed work was being done to resolve these problems.
- Wards used printed patient handover sheets as a reference tool to help them deliver care and treatment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent to treatment means that a person must give their permission before they receive any kind of treatment or care. An explanation about the treatment must be given first. The principle of consent is an important part of medical ethics and human rights law. Consent can be given verbally or in writing.
- For consent to be valid, it must be voluntary (the decision made by the person themselves) and informed, and the person consenting must have the capacity to make the decision.
- If a person does not have the mental capacity to make a decision about their treatment, professionals can make a 'best interest' decision. However, the professional must take reasonable steps to consult with the patient's family or closest person before making these decisions.
- We were concerned that DNACPR decisions were not always made in line with national guidance and legislation, for example the Human Rights act and Equality act.
- We looked at 24 DNACPR forms in total; we saw two positive examples on ward Vickers 4 where families had been given involved in DNACPR discussion.
- In six instances, 25% of the forms we looked at, the patient did not have capacity to be involved in the decision and there was no evidence in records that family or friends had been consulted.
- In two situations, discussions had not been had with patients who had capacity as they were "too unwell".
- We spoke with the Medical Director about DNACPR forms; they told us they were aware of issues related to a lack of countersignature by a consultant and a lack of documentation of capacity assessments. After our inspection, senior staff told us action was being taken to address this.
- A DNACPR audit took place in February 2015 on the MCPU to assess the accuracy of form completion and to compare results with those of 2014. Results were variable; for example 100% of forms had the patient name and hospital number included, but only 65% had the next of kin details. The timescale for forms being countersigned by a consultant ranged from one to 28 days. This meant sometimes decisions were made by junior doctors. Where DNACPR decisions were not discussed with a patient, 60% were discussed with the family, 40% were not.
- There were 14 recommendations made as a result of the audit. These included making every effort to involve patients in discussions. A further recommendation was to make and document best interest decisions and involve families where this was appropriate. At consultant ward rounds and team handovers, DNACPRs were to be reviewed and missing details completed. There were plans to re-audit.
- The Deprivation of Liberty Safeguards (DoLS) aim to protect people who lack mental capacity, but who need to be deprived of their liberty so they can be given care and treatment. In order to do this, written authorisation must be sought. The trust's DoLS policy and flowchart had been due for review in October 2013.
- We spoke with staff on the MCPU about patients without capacity who try to leave the unit. They told us that this did occur sometimes more than once a week, but they had never used the DoLS process. The trust had sought advice regarding this. We spoke with three members of staff on the MCPU who demonstrated poor awareness of the DoLS process.
- We spoke with senior nurses and the DoLS clinical lead about DoLS and capacity assessments. They told us a "pragmatic approach" was taken. They said in "high risk" cases DoLS requests were sent to the local authority but it could take a long time for them to respond.
- We saw five patients had DoLS in place on Brearley 7. In one patient's notes there were signed authorisation forms, but no other record to indicate the patient had been deprived of their liberty or the reason why.

End of life care

Are end of life care services caring?

Good

We rated caring as good. We found:

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

However, we also found:

- There was no individualised or advanced care plan where the wishes and decisions of patients could be recorded.

Compassionate care

- We found evidence of very compassionate, sensitive end of life care to patients at the hospital.
- There were examples of outstanding care on the MCPU. The ward clerk on the MCPU helped patients write goodbye letters and memento notes to their young children or other family members. The ward clerk had won a trust 'thank you' awards for this.
- There was an oral history project on the unit which was carried out with the help of a charity. If patients wanted to participate, CD recordings were made of their life stories and the discs were given free of charge to their families as a keepsake.
- There was a 'resident' professional photographer who took photographs of patients and families together. These were framed and given to families free of charge. This was funded by the MCPU charity.
- We saw patient's dogs being brought in to visit them on the MCPU. Staff told us the pets were able to stay overnight if the patient wanted this to happen.
- A 'Pets as Therapy' dog visited the unit each week with their owner; staff told us the patients enjoyed these visits.
- There was an alcove area on the MCPU overlooking a garden, which could be used as a quiet sitting area. Staff told us they had held wedding ceremonies in this area.
- Bereavement appointments were carried out on the MCPU. This meant if bereaved families did not want to go to the main office, they could return to the unit to collect the death certificate. Three staff members had been trained to do this.
- All registered nurses on the MCPU were trained in verification of expected death. That meant families did not have to wait for a doctor to do this if the doctor was busy elsewhere.
- We saw lot of thank you cards on the MCPU. Messages from patients and family members included;
- "nurses ensured my relative was cared for with dignity and compassion at all times"
- "The care I received was first rate care, an excellent standard".
- We saw there was a close team on the MCPU. Staff supported each other during difficult times. One staff member had returned to work after bereavement and said they had been looked after by their colleagues.
- Porters told us they treated deceased patients as if they were a family member. They said this wasn't learned in training, it came out of respect for people.
- Mortuary staff told us when they were with a family, time was irrelevant; they stayed with families as long as was needed.
- Bereavement office staff provided hot drinks for bereaved families while they were given the information they needed. The information included what official steps had to be taken after someone had died.
- Bereavement staff made appointments with the registrar so that families did not need to do this.
- There was free parking for families attending the bereavement office.

End of life care

- Staff on wards told us how they ensured cultural and spiritual wishes of patients were met. Families were able to participate in preparing their loved one to go to the mortuary if they wished.

Understanding and involvement of patients and those close to them

- Three out of five relatives we spoke with told they had been kept up to date about their loved ones condition and given information in a way they could understand.
- Two patients we spoke with told us they had the information they wanted and had been involved in their care.
- We saw one set of notes on a renal ward where discussions had taken place with family members about the possibility of the patient dying in the ambulance on the way to the hospice.
- One of the new nursing care guidelines for use at end of life was 'Care of the family and relevant others'. There were guidelines within the 'guidance for the care of the person who may be in the last hours to days of life'. This included an overview of the conversation to have with the patient and relevant others when a patient was believed to be dying. The guidance suggested staff develop a care plan to include;

- What to expect as the patient neared the end of life
- What symptoms may occur
- The preferred place of death
- The needs of the family.
- We were shown a leaflet with information for families and relevant others; it was called 'As the end of life approaches'. Part of the document was in the form of a relatives diary; it could be used to ask staff questions.
- The trust participated in the National Cancer Patient Experience Survey in 2014 (the 2015 results were not published at the time of our inspection). The trust was in the top 20% of trusts in England for;
- Staff giving information about support groups and financial help
- Taking part in cancer research being discussed with the patient,
- Staff telling the patient who to contact if they were worried after discharge.

- The trust was in the bottom 20% of trusts in England for;
- Patients being given enough privacy when discussing their condition or treatment. (this result was the same as 2013)

- In Sheffield, 61% of families felt they were given enough information to provide care at home. This had fallen from 64% the year before. It was in line with the England average.
- Mortuary staff told us if a bereaved relative was a wheelchair user or not able to stand beside the mortuary trolley, a height adjustable trolley would be used to make viewing the deceased patient more comfortable.
- We saw plans for 'Dying Matters' week 2016, where the public would be involved to participate as they had done in recent years. The National Council for Palliative Care set up the Dying Matters group to help people talk more openly about dying, death and bereavement, and to make plans for the end of life.

Emotional support

- Staff we spoke with understood the impact of end of life care on the patients and family well-being.
- Staff spoke of emotional support they would give to patients and those close to them.
- Spiritual multi faith chaplaincy support was available 24 hours a day.
- A number of staff told us they could have counselling and debriefing if they wished.
- Bereavement office staff had carried out a survey to find out the views of families. The survey was carried out in March 2015. The results were variable; almost half of the respondents said they were given a choice of times to go to the bereavement office; that meant the other half were not. Results showed 99% of people were met in a sympathetic and understanding manner and 100% said they had just the right amount of time and were informed of what to do.

Are end of life care services responsive?

Good

We rated responsiveness of end of life care services as good.

We found;

End of life care

- There was a designated 18 bed specialist palliative care unit providing specialist level assessment, care and support for end of life care patients. Care was led by consultants and a range of staff responded to patient needs. There had not been any complaints on the unit for three years.
- The individual needs of patients with dementia were met. People living with dementia who needed to return to the Macmillan palliative care unit for treatment could come at the same time the next day and efforts were made for them be looked after by the same members of staff.
- There was seven day specialist palliative care clinical support to the hospital.
- During the twelve months from April 2014, 97.3% of patients were seen within 24 hours of referral to the specialist palliative care team.

However, we also found;

- The trust did not monitor if patient choice around preferred place of care or death was met.
- Patients could wait up to a week for a bed on the palliative care unit.
- There were delays in the fast track (rapid) discharge process.
- There were limited facilities for family members who wished to stay overnight on the palliative care unit.

Service planning and delivery to meet the needs of local people

- Services were commissioned by Sheffield Clinical Commissioning Group (CCG). We saw the trust five year plans where it was noted that the introduction of a block contract for specialist palliative care ward visits since April 2012 had limited investment in the service.
- There was an 18 bed ward, the Macmillan palliative care unit (MCPU) specifically providing specialist level assessment, care and support for patients with unresolved complex needs and unstable symptoms There was consultant led care on the MCPU and a planned multi- disciplinary team approach to end of life care.
- The MCPU accepted patient referrals from a wide range of sources. GPs, hospices, hospital nurses and doctors and patients themselves.
- Referrals were discussed with the patients GP or hospital consultant and were considered at a weekly referral meeting on the MCPU.
- The specialist palliative care team provided seven day clinical support to the hospital.
- We saw there was development of a rapid discharge pathway in the emergency department for patients who wished to go home to die rather than be admitted to hospital.
- If patients or families requested a side room, staff tried to accommodate their wishes. This was not always possible due to rooms being used for infection prevention and control.
- There were limited facilities family members to stay overnight on the MCPU. Staff told us they sometimes put a mattress on the floor or relatives could sleep in the recliner chairs in the side room. Eighteen new recliner chairs had just been ordered for the unit. We saw there were plans to better accommodate families when the new (charity funded) building was constructed. There was a team of eight chaplains who provided spiritual care for patients, relatives and staff. NHS Chaplaincy guidelines (2014) indicated there should be 13 chaplains for the size of the trust.
- We visited the viewing room in the mortuary. It was neutrally decorated and the lights could be dimmed. Entry to this room was via an unmarked door leading off a main corridor into a small lobby area. Mortuary staff told us families would not have to find the room unaided, they would always be accompanied by a staff member or volunteer.
- There was a cupboard with faith items, (for example, holy books for different faiths) should families wish to use them. There was also a relative's waiting room with seating, tissues were provided and there was a nearby accessible toilet.
- To the side of the main viewing room was a 'no touch' viewing area behind a glass window. Mortuary staff told us this area had never been used.
- Since the withdrawal of the Liverpool Care Pathway (LCP), there was no way to measure if patient choice around preferred place of care or death was met. This meant because it was not identified, this information could not be used to improve or develop services.
- There was a development of a questionnaire which was planned to be sent to bereaved relatives or carers. The questionnaire was expected to contain a set of questions about the preferred place of care. The questionnaire was due to start being sent out to relatives in January 2016.

End of life care

- We saw preferred place of death was recorded on the handover sheet on the MCPU; nurses told us this information was not collected.
- The trust was a pilot site for the Department of Health Medical Examiners scheme. The cause of all deaths that did not need to be investigated by a coroner were confirmed by a medical examiner before a medical certificate of cause of death was issued, or was established by a medical examiner. The medical examiner scrutinised the deceased person's medical records and could choose to carry out external examination of the body. The medical examiner (or an officer acting on his or her behalf) also speaks with a member of the bereaved family.

Meeting people's individual needs

- There was a comprehensive assessment form in use on the MCPU. We saw that patient's spiritual, psychological and social needs were taken into account on the MCPU.
- Staff told us of situations when end of life patients living with dementia needed to come back to the unit for treatment of their symptoms. Staff arranged for them to come at the same time of day the next time and made efforts for them to be treated by the same staff each time to reduce distress and anxiety for those patients.
- We spoke with therapists from the Cavendish care charity. They came to the MCPU three times a week and offered complimentary therapies to patients. Therapies included massage, reflexology, reiki and 'healing' sessions. The sessions were tailored to patient's individual needs and preferences. They were free to patients; the cost was met by charitable funds.
- There was no individualised or advanced care plan where the wishes and decisions of patients could be recorded. The SBAR draft guidance contained a page which suggested an approach to spiritual care needs such as asking about faith and the people who are important to the patient; however there was no set format or tool to record these. Two nurses on a cardiology ward told us advanced care planning happened too late. They said patients were imminently dying before their choices were explored.
- We saw records on ward Hadfield 6 for an end of life patient. There was no individualised care plan, or anything in the notes to suggest they needed end of life care. We spoke with staff about this and were told it was handed over verbally if someone needed end of life care. There was no record of spiritual wishes or the patient's choices around death. We were concerned this relied on individual staff knowledge, skills and memory.

Access and flow

- From April 2014 to March 2015, there had been 2812 referrals to the specialist palliative care team. Of these 73% (2047) were cancer patients. The remaining 27% (765) were non-cancer patients.
- The number of referrals had increased from the year before; from April 2013 to March 2014 there had been 2524 referrals. Of these 78% were cancer referrals and 22% non-cancer referrals.
- This meant there had been an increase in the total number of referrals, there had also been an increase in the number of non-cancer patients seen by the team. They told us they had worked to address the imbalance by close liaison with other services to reach end stage heart and respiratory failure patients.
- A total of 97.3% of patients were seen within 24 hours of referral from April 2014 to March 2015. This decreased to 93.9 % during a six month period from 1 April 2015 to 30 September 2015.
- When the patients were not seen within 24 hours this was due either to a future time / date being requested; (often to coincide with the patient being given a diagnosis). A further reason for patients not being seen within 24 hours was when the request was non- urgent or the workload of the specialist palliative care team resulted in a delay.
- The specialist palliative care nurses had moved to seven day working without an increase in staffing. One nurse worked each weekend day at Northern General Hospital; on average they saw 10 new patients each day. On a weekday there was a minimum of two nurses, who saw an average of 15- 20 patients. They told us they were just able to keep up to date with referrals but it was difficult with their current numbers of staff. Staff described this as "firefighting".
- Staff told us they prioritised referrals to the MCPU based on patient need.
- Referrals were discussed on the weekly MDT referrals meeting. Staff told us patients could wait up to a week for a bed after they had been referred. They told us some patients died before they could be transferred to the unit. Senior staff told us when there was a wait for

beds, patients still received specialist input from specialist palliative care services .There was a 'weekend leave' process on the MCPU; patients could go home overnight or for the weekend, and the bed would be kept for them.

- A fast track discharge is one where a patient has a rapidly deteriorating condition which may be entering a terminal phase, that is to say they may be dying.
- The national process involves an assessment for NHS Continuing Healthcare funding to enable patient needs to be urgently met; (for example to enable them to go home to die or to provide appropriate end of life support to be put in place either in their own home or in a care setting).
- The trust process included a referral to the 'Transfer of care' nursing team. They carried out a nursing assessment and requested ward doctors to compete the fast track tool. We saw this was done in a timely way. The fast track form was faxed to continuing healthcare.
- In February 2015, 66% of fast-tracked patients were discharged after three days; in March, this rose to 80%; in May 2015, 90% were discharged after three days.
- We saw from six patient records that there were delays of between two to three weeks before a funding decision was made by CHC. Staff told us this was not unusual.
- The national fast track process indicates completed documentation is sent to commissioners for "immediate action". When the commissioners receive the fast track tool this should be accepted and actioned immediately. It is not appropriate for individuals to experience delay in the delivery of their care package. (Department of Heath 2012). After our inspection the trust provided evidence that 46 % of fast track requests were approved by commissioners on the same day and a further (44%) the day after. It had been identified that some fast tracks had to be returned because the forms were completed incorrectly and work was being done to improve this.
- We saw on out of hours form was in use in the emergency department (ED). This meant if they were discharging an end of life patient from ED they faxed information to the out of hour's service to inform them of the patient's needs.
- ED staff told us there was no way to identify if a known end of life patient came in to ED. End of life patients who did not need to be an in-patient might be admitted. We saw that a new discharge pathway was being developed, but were not clear when this would be in use.
- There was a 'clinical information portal' in development so that ED staff could access electronic patient record systems. This would enable them to see if the patient was known to specialist palliative care services. We did not find out when this development work would be finished.

Learning from complaints and concerns

- We saw there had been no complaints on the MCPU for three years.
- Incidents and concerns were discusses at weekly team meetings on the unit, and a weekly bulletin was printed and displayed in the staff room so staff may learn from previous incidents.

Are end of life care services well-led?

Requires improvement

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

- There was no internal strategy in place for end of life care at the trust. We could not ascertain how progress towards achieving the five year plans leading up to 2017 was measured.
- In response to the 2013 review of the Liverpool Care pathway, the trust had produced guidance. However, this had not been made available until October 2015. Not all staff were aware of the guidance.
- There was limited monitoring of quality of care for end of life care.
- The trust did not monitor if patients achieved their wish for preferred place of care or death. As this was not routinely identified, this information could not be used to improve or develop services.
- There was a focus on the delivery of excellent care on the Macmillan palliative care unit, however opportunities to deliver the same standards on general wards, where greater numbers of end of life care patients were cared for, had not been fulfilled.

However we also saw;

End of life care

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

Vision and strategy for this service

- There was no internal strategy in place for end of life care at the trust. We spoke with senior leaders who acknowledged there was no strategy. An end of life strategy group were responsible for providing provided the vision and strategy for end of life services in hospital and community services. The group were in the process of developing a strategy for the service provided by the trust. We did not know when this would be put in place.
- We found the absence of a strategy had resulted in staff not knowing the vision for end of life care. We found front line staff were committed to caring for those approaching the end of their lives; however, staff could not tell us their role in achieving the strategy.
- We saw a five year plan for specialist medicine from 2012- 2017. It included plans for end of life care as one of the six specialisms in the document. The document was written in 2012, and included an assessment of the trust position at the time, their aims over five years and how this was to be achieved. We understood this to be the 'vision' for the service. There was no detail or timescales to determine how different parts of the plan were to be achieved.
- We saw that plans had changed since the five year plan was written. For example, one statement specified by 2017 the specialist palliative care team would have led the implementation of advanced care planning and AMBER bundle across the trust. This was no longer the plan in 2015 when we visited; the trust had stopped the implementation of the AMBER care bundle after four wards were using it. We did not see a framework or tool where these changes could be explained or evaluated.
- The goals of the medical director were to raise the profile of end of life care and to increase the number of non-cancer patients seen by the specialist palliative care team.

Governance, risk management and quality measurement

- There were quarterly governance committee meetings. We reviewed minutes from these meetings and found that serious incidents, complaints and the risk register were some of the agenda items discussed.
- The service participated in national audits, such as the care of the dying audit.
- There was limited monitoring of quality of care for end of life care. The medical director agreed there was a need for more robust, strong data to support the general 'feeling' in the trust that the service was doing well. However, there was a comprehensive audit programme for the specialist palliative care team for the coming year. This was to be used to monitor quality and plan where future action should be taken.
- We spoke with the medical examiner at the hospital. They were in post to consider themes and risk management around cause of death.
- There were close links with the local hospice and the MPCU was working with them to develop similar processes.
- The Deprivation of Liberty Safeguards (DoLS) policy expired in October 2013. The flowchart to guide staff in DoLS decisions was also out of date. This meant that staff may not be making decisions in line with national guidance and legislation, for example the Mental Capacity Act, Human Rights Act and Equality Act. After our inspection, senior staff told us out of date policies and guidelines remained valid until they were replaced.
- Trust audit had identified gaps in DNACPR forms; the issues remained at the time of inspection. We spoke with the Medical Director about DNACPR forms; they told us they were aware of issues related to a lack of countersignature by a consultant and a lack of documentation of capacity assessments.

Leadership of service

- The medical director was the executive lead for end of life care and a palliative care consultant was the clinical lead. We saw that staff were clear about their roles and responsibilities.
- In response to the 2013 review of the Liverpool Care pathway, the trust had produced guidance. However, this had not been made available until October 2015. Not all staff were aware of the guidance at the time of inspection.
- We spoke with the medical director about the lack of an end of life care strategy. They told us there were several

reasons for this, including awaiting publication of NICE guidance and a replacement national care pathway. They also told us there were senior clinical leaders in each directorate.
- There was a focus on the delivery of excellent care on the Macmillan palliative care unit, however opportunities to deliver the same standards on general wards, where greater numbers of end of life care patients were cared for, had not been fulfilled. After our inspection senior staff told us in an attempt to address this a senior leaders' training programme had been developed as part of the plan improve palliative care on general wards.
- We saw positive examples of local leadership on the MCPU and in the palliative care team from both a nursing and medical perspective.
- We saw that the palliative care consultants were visible and approachable. Junior doctors told us they received good direction and support from the consultants.
- Ward staff told us the specialist palliative care team were very supportive. Ward nurses knew them by name and were able to give us examples of their involvement in patient care.

Culture within the service

- We found an open and friendly staff culture at the hospital.
- There was a learning culture. Staff on the MCPU told us they had learning opportunities and set annual goals and objectives in line with those of the service.
- Staff were open about reporting risks or incidents and there was a philosophy of learning from incidents and complaints.

Public engagement

- We saw that the trust gathered views and opinions of patients and relatives. The trust participated in the National Care of the Dying Audit for Hospitals (2013-2014)
- They did not participate in the survey of bereaved relatives as this coincided with the Christmas period at the time. The trust felt this might be a difficult time for families so withdrew from participating in the bereaved relatives' survey with view to carrying out a relative's survey at a more appropriate time.
- We saw the bereavement office staff carried out a survey in March 2015.
- The MCPU surveyed patients who had used the service from April 2014 to March 2015. Staff told us these results were used to improve future care for patients.
- The furniture and wall colours in the relatives lounge area had been chosen by visitors.

Staff engagement

- There was engagement with and involvement of staff on the MCPU. They participated in team meetings and were asked to contribute to improving the service.
- Two nurses on the MCPU said they had raised concerns several times over staff being taken from the unit to work on other wards. They said it felt like their concerns were not taken seriously.
- We asked staff what the trust vision and aims for end of life care was, but they were not able to tell us.

Innovation, improvement and sustainability

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

Outpatients and diagnostic imaging

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Outstanding
Overall	**Outstanding**

Information about the service

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

At the Northern General Hospital (NGH) site, there were six main outpatient (OP) areas. Orthopaedic surgery, plastic surgery, general surgery and cardiology were the main OP services. Some services, such as orthopaedics and cardiology had their own specific outpatient departments. Other locations, such as 'Outpatients 1,' hosted multiple surgical and medical specialties.

Many services at the site operated specialist OP services. These included renal, spinal injuries, palliative care and metabolic bone services. These services were integrated with other key adjacent services, such as the DEXA bone density scanning facilities in the metabolic bone services.

Between July 2014 and June 2015, there were 307106 OP appointments at the Northern General Hospital.

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

The MIMP services provided at NGH included nuclear medicine and radiopharmacy, emergency department imagining, MRI, CT, ultrasound, fluoroscopy, angiography, and general x-ray plain film.

During our inspection we visited the following OP areas:-

- Fracture clinic in orthopaedic outpatients
- Plaster room in orthopaedic outpatients
- Respiratory clinic and chest clinic in Brearley OPD
- Pain clinic
- Surgery upper Gastrointestinal (GI)
- Diabetes clinic and young people's diabetes clinic
- Cardiology OPD and cardiac physiology
- Spinal injuries unit
- Renal OPD

We also visited the laboratory medicine centre, which housed the pathology laboratories on the NGH site. This had been open for around three years and clinical laboratories, including haematology, blood transfusion, biochemistry, serology, virology, immunology and microbiology, were all located on this site.

We spoke with 28 members of staff in radiology, 68 members of staff in OP and eight members of staff in pathology. These included managers, nurses, medical staff, scientific/technical staff and administration staff. We also spoke with 30 patients and two relatives. In OP, we reviewed 13 sets of patient records and six sets of notes reviews. In MIMP, we looked at 11 electronic patient records. We looked at a range of other records such as policies, procedures and audits.

Outpatients and diagnostic imaging

Summary of findings

We rated the service as outstanding overall.

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

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

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

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

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

Space was limited in the fracture clinic and was not designed to meet the needs of patients.

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

Are outpatient and diagnostic imaging services safe?

Good

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

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

However;

- Safety checklists within imaging services were not always completed as required. Internal audits had identified this issue and the service was working towards improving the compliance rates.
- In some areas, the premises and equipment were not suitable for the purpose for which they were being used. For example, in the orthopaedic fracture clinic waiting areas there were nine chairs for clinics of up to 100 patients. This meant there was a risk of further harm to patients with fractures, using crutches or other mobility aids.

Incidents

- There was evidence of learning from incidents; investigations took place and appropriate changes were implemented. Incident management and response was through the trusts online reporting system.

Outpatients and diagnostic imaging

- Northern General Hospital outpatients and diagnostic imaging had reported 1015 incidents from September 2014 to August 2015. All of these had been categorised as either insignificant or minor.
- There had been no 'never events' reported in the past 12 months; never events are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.
- Staff told us managers were trained to locally manage and investigate incidents within their own areas. The managers and section heads told us they encouraged staff to openly report incidents.
- Staff we spoke with across all of the areas visited confirmed that they were actively encouraged to report incidents. Staff all told us they knew how to report incidents and lessons learnt were shared. For example, in the orthopaedic OP fracture clinic staff told us the numbers of incidents had decreased because of shared learning with the emergency department.
- From reviewing minutes of meetings, we saw that learning from incidents took place and appropriate changes were implemented.
- Staff told us incidents were reviewed and actioned as soon as possible. For example, in upper GI surgery, OPD staff told us they had reported a trip hazard on a drain cover and this had been fixed immediately.
- Pathology incidents had increased over the previous 12 months; however, this was due to increased reporting and did not indicate that more incidents were occurring. We reviewed the minutes of the pathology quality meetings and saw incidents were discussed and action plans agreed.
- In cardiac physiology, we witnessed a physiologist identify and report an incident while carrying out an echocardiogram. An echocardiogram, or "echo", is a type of ultrasound scan used to look at the heart and nearby blood vessels. The physiologist realised the patient name did not match the departments list; it transpired that the ward had sent the wrong patient to the department. The patient's wristband was also missing. The physiologist contacted the ward and completed the incident report immediately. The patient who should have had the procedure had to be rebooked because of this error.
- Staff received induction and training on how to report incidents. Learning from incidents was communicated through team meetings and monthly incident bulletins circulated to all staff. Staff we spoke with confirmed incidents and any lessons learnt were discussed at staff meetings.
- In radiology, managers had 'their own incident dashboards', these assisted them in monitoring incidents reported internally and externally. Incident dashboards also improved the timeliness of incident reviews and investigations. The directorate reported that monthly exceptions reports showed that 98% of incidents were closed within the trust's target of 35 days.
- The Radiation Safety Steering Group (RSSG) monitored the numbers of radiation incidents reported to the Care Quality Commission (CQC) under IR(ME)R regulations. The number of IR(ME)R reported incidents (exposures 'much greater than intended' and unjustified exposures) had increased over the previous 12 months. The clinical directors and directorate manager told us there had been an increase in externally reportable IR(ME)R incidents mainly due to a change in the 'interpretation of the legislation and in response to actions as determined by CQC'.
- This was confirmed in the RSSG annual report for April 2013 to March 2014 presented to the trust's Healthcare Governance Committee. The report stated, 'clarification had been sought from the CQC IR(ME)R inspectorate and the trusts reporting criteria amended accordingly'. The report also stated that these changes 'will result in a higher number of incidents being reported externally, but it was stressed that this would not be as a result of an increased number of incidents'.
- The ionising radiation sub group report to the RSSG July 2015 highlighted the on-going work to reduce the numbers of IR(ME)R incidents. This involved radiographers using the 'have you paused and checked' initiative. This initiative is a nationally recognised clinical imaging examination IR(ME)R operator safety checklist carried out before and after exposures.
- Pause and check operator checklists were displayed within the radiology treatment rooms. Staff confirmed they produced reflective statements from errors and these were reviewed with their line managers to identify learning outcomes. They also confirmed that a monthly bulletin detailing incidents was circulated to all staff to enable wider learning. The November and December 2015 bulletins highlighted safety concerns and point of good practice.

Outpatients and diagnostic imaging

- In radiology, the clinical, scientific and nursing directors together with the matron, directorate and governance managers attended directorate monthly clinical governance committee meetings. The committee routinely reviewed all incidents in order to identify trends. We saw from the June, July and September 2015 meeting minutes that incidents were reviewed and action notes recorded. Actions were monitored, and followed up appropriately at subsequent meetings.
- Managers, section heads were aware of their responsibilities under the Duty of Candour legislation. This was discussed and recorded in the radiology minutes of the May 2015 section head meeting. The majority of staff we spoke with were also aware of their responsibilities under the legislation. Duty of Candour was part of the trusts induction programme and was included as part of the electronic incident reporting system for completion by staff.

Cleanliness, infection control and hygiene

- The environment was visibly clean in all of the areas we visited. Hand sanitiser was readily available and we observed staff washing their hands and using hand wash gel appropriately. Staff practised good hand hygiene before and after contact with each patient.
- We saw posters were on display reminding staff and visitors about hand hygiene. We also observed infection control notices and information on display. We observed equipment and surfaces with 'I am clean' stickers attached.
- We saw staff wearing personal protective clothing such as disposable gloves and aprons. Staff adhered to the 'bare below the elbow' policy.
- Clinical and domestic waste was disposed of correctly and sharps boxes were not overfilled. Appropriate containers for disposing of waste including clinical waste were available and in use across the imaging departments. Waste was safely managed and staff disposed of sharps items safely.
- The outpatient and radiology departments carried out regular audits as part of the trust's infection prevention accreditation programme. This set the standards for infection prevention and control practice across all directorates. Compliance was assessed by monthly audits and quarterly compliance reports. These audits included aseptic technique, hand hygiene, cleaning and decontamination of equipment, care of central venous catheters and standard precautions. These audits monitored compliance with key trust policies. Between October 2014 and September 2015, NGH scored between 96% and 100% in these audits.
- The trust undertook an infection control accreditation programme. This programme sets standards for infection prevention and control practice. The aim was to optimise and assess infection prevention and control practices in clinical teams throughout the hospital in order to reduce infection rates. The July 2015 MIMP clinical governance minutes recorded that infection control accreditations were up to date. Infection control results reported in the September 2015 minutes showed radiology achieved 99% compliance.
- The radiology waiting and recovery areas appeared clean, tidy and uncluttered. Patient waiting and private changing areas were clean and tidy. Single sex and disabled toilet facilities were available and these areas appeared clean and tidy.
- Staff in radiology were responsible for maintaining the cleanliness of the radiology equipment in accordance with infection prevention and control (IPC) standards. Imaging and examination room cleaning schedules were available in all areas and were up to date.
- Staff in radiology could explain the procedures to follow for managing patients with suspected or confirmed infections.
- Patients we spoke with all told us they were happy with the cleanliness, one patient in the fracture clinic told us, "It's a nice clean place."
- The respiratory clinic had separate areas allocated for use by patients with cystic fibrosis (CF) to minimise the risk of cross-infection. Staff told us rooms used by patients with CF had an 'amber clean' after use and were left for an hour. Staff said the rapid response cleaning team carried out the amber clean' between patients, supported by the nursing staff.
- Appropriate infection control measures were in place in pathology. For example, inspectors were required to wear protective laboratory coats when entering laboratory areas.

Environment and equipment

- The maintenance and use of the premises, facilities, and equipment were designed to keep people safe. However, space was limited in the fracture clinic, which was a risk to patients in that area.

Outpatients and diagnostic imaging

- Emergency trolleys in all areas were accessible and checked.
- All of the equipment we checked in OP had been electrically tested (Portable Appliance Testing). Daily, weekly and monthly equipment checks reviewed were all in date with no omissions.
- All of the departments were clearly signposted within the hospital.
- The spinal injuries unit was the second largest in the country and was housed in a relatively new, custom-built block. We observed it appeared clean, tidy, and appropriately adapted for the largely disabled patient group.
- The renal OPD was housed in the Sorby Wing on the ground floor of the Sheffield Kidney Institute.
- The diabetes centre was housed in a purpose-built unit, which brought together a large multidisciplinary team, for the benefit of the patient.
- In the orthopaedic OPD, we observed there was a lack of privacy blinds, as the ones in place were broken. The sister told us new blinds had been requested; these were on order at the time of the inspection.
- The laboratory medicine (pathology) centre was a large building, which had been open for around three years. It housed state of the art clinical laboratories, including haematology, blood transfusion, biochemistry, serology, virology, immunology and microbiology.
- Security in the pathology building was good. Inspection team members were required to sign in and out and restricted areas had security devices in place to prevent unauthorised entry.
- There were systems and processes in place to ensure the maintenance and servicing of radiology equipment. The directorate had an up to date inventory of all of the radiology equipment and the planned preventative maintenance (PPM) schedules.
- We were told by staff that a capital replacement scheme for equipment was developed and plans were in place for two additional MRI scanners and replacement of four CT scanners over the next two years. Staff told us one of the two new MRI scanners was for the NGH.
- During the course of our inspection, we observed specialised personal protective equipment was available for use within radiation areas. Staff wore personal radiation dosimeters (dose meters) and these were monitored in accordance with legislation. A radiation dosimeter is a device that measures exposure to ionising radiation.
- We saw that the majority of the equipment we looked at was routinely checked and in date. Emergency resuscitation equipment was readily available for use within the departments and checks of the equipment were up to date. Radiation warning signs were displayed along with the use of illuminated do not enter signs within all modalities.
- Radiation local rules were displayed and described the duties undertaken by staff in accordance with the local rules. Local rules are written to enable work with ionising radiation to be carried out in accordance with the Ionising Radiations Regulations (IRR99). It is the primary responsibility of the Radiation Protection Supervisor (RPS) to supervise work and observe practices in order to ensure compliance with these regulations. All modalities had appointed and trained RPSs.
- Radiation Protection Advisors (RPAs) were employed within the radiology service. They attended the RSSG meetings and undertook annual risk assessment inspections of the radiology services at each of the MIMP directorate locations. The RPAs produced an annual report.
- The purpose of the inspections and reports was to evaluate compliance with legislative requirements associated with the radiation safety of patients, members of staff and the public. The findings from inspections were communicated to the trust Chief Executive and other responsible persons.
- We saw from the 2014 and 2015 inspection reports supplied by the trust that adequate standards of compliance were achieved. Where compliance fell short, requirements were issued and recommendations for action identified. The reports also contained follow up on previous requirements and recommendations.
- In radiology, the clinical director and directorate manager told us the age, design and layout, along with increased demands for radiology, was having a significant impact on the privacy and dignity of patient care. Managers had escalated this issue and it was on the directorate risk register. We saw patient waiting and recovery areas appeared old and were in need of upgrading. The directors said this was a 'big focus' for them at present and there were plans to upgrade the department over the next few years.

- In radiology, we observed cluttered clean utility and consumable storerooms. We saw there were many areas of the walls with minor paintwork and plaster missing within these areas. We brought this to the attention of the manager.

Medicines

- Appropriate arrangements were in place in relation to obtaining, recording and handling of medicines. Medicines were prescribed and given to people appropriately and were stored securely in locked cupboards.
- However, we found a few medicines that were out of date and a stock recording error. We bought these issues to the attention of staff, who rectified the situation immediately. For example, in the respiratory clinic, we found two items in the medicines cupboard, which were out of date. The staff nurse were removed these immediately and informed her senior.
- Staff in the renal OPD told us there were six nurse prescribers in the department; this meant nurses could write prescriptions for patient medicines.
- Medicines including controlled drugs (CDs) were all stored correctly. The senior nurses were responsible for checking CDs and medicines. They were also responsible for the safe management and control of medicine keys.
- In radiology, the CD registers and order book were all checked and signed correctly. Staff checked the drug fridge temperatures in the x-ray department; records of these checks were up to date. We saw that medical gases and contrast media was stored safely.
- We visited radiopharmacy and spoke with the manager of the service. The department was a 'state of the art' Medicines and Healthcare products Regulatory Agency (MHRA) Licenced radiopharmacy serving all of the trusts locations.
- We saw radiopharmacy staff wore personal dosimeters and finger dosimeters in accordance with the regulations. A dosimeter is a device that measures exposure to ionizing radiation.
- There was a range of safety and security procedures in place to ensure compliance with national legislation. The radiopharmacy service was inspected two yearly by all of the relevant radiopharmacy professional, safety and regulatory agencies.

Records

- People's care records were written and managed in a way that kept people safe. However, in the upper GI surgery clinic, we observed medical lists for the clinic were on display on the reception desk; other patients could see these. We observed medical notes were left unattended in this clinic.
- We reviewed four sets of patient notes in the fracture clinic. All were in good condition; pages were secure and could easily be found as they were sectioned off. The writing was legible, dated and signed.
- Senior staff in the respiratory clinic told us medical records sent patient notes to the department. Temporary sets of notes were only used occasionally, if there were no notes.
- In the respiratory clinic, we reviewed three sets of referral records and subsequent requests for investigations and results. The records were all correctly completed with patient details, including hospital numbers, on every page.
- In the spinal injuries unit, we reviewed four sets of patient notes. These were handwritten but the service was planning to move to electronic notes. All of the notes were legible, signed, dated and timed. Notes were easily accessible.
- In cardiac OPD, we reviewed six sets of patient reports. These were of a high standard and comprehensive. A consultant had signed them and copies were sent to the patient and to the GP. We reviewed six sets of patient notes in cardiac OPD; which were also of a high standard.
- In radiology, we found staff managed and handed over inpatient case notes safely. We reviewed 28 electronic patient records (across the three hospital sites) specifically to check whether radiology staff had completed the safety checks for MRI, pregnancy and interventional WHO safety surgical checks. We found these were all completed.

Safeguarding

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

departments had undertaken Level 1 safeguarding training for children and young people and Level 1 and Level 2 vulnerable adults training; 81% had Level 2 training for children and young people. This was against a trust target of 90%. Hospital specific data was not available.

- Staff we spoke with were able to describe to us the action they would take if they had any safeguarding concerns for a child or an adult. Staff were aware of the trust safeguarding policies and the directorate safeguarding lead they could contact for advice and support if they had any concerns.
- The MIMP directorate did not routinely provide radiology for children. A nominated safeguarding lead trained at level three provided in-house advice.
- There was a radiation safety infrastructure in place which included the reporting of radiation incidents from local clinical teams and section heads into one of five radiation safety sub groups for; Ionising radiation (x-ray), non- ionising radiation (MRI and Ultrasound), radiotherapy (sealed sources), nuclear medicine (unsealed sources) and dental (x-ray).
- The purpose of the sub groups and RSSG was to ensure radiation safety issues requiring action by the trust were reported and acted upon appropriately in order to achieve on-going legislative compliance and ensure the safety of staff, public and patients.
- The minutes and action notes from the February and July 2015 RSSG meetings included radiation safety reports from each sub group. These reports were reviewed the meetings and any further actions recorded and followed up appropriately.
- The World Health Organisation (WHO) developed safety checklists after 'extensive consultation aiming to decrease errors and adverse events, and increase teamwork and communication in surgery'. The directorate used two types of checklists the WHO radiology intervention and an adapted check list the 'Sheffield Teaching Hospitals Surgical Safety Checklist Interventional Radiology' to ensure it was suitable for the setting in which it is used. Staff told us only vascular clinicians used the WHO checklist. The directorate's governance coordinator confirmed this.
- We saw different methods employed by clinicians for recording each of the checks. Some clinicians preferred to tick at the side of each safety check and enter not applicable (N/A) when not appropriate, others clinicians signed each section of the checklists.
- Standard procedures for completing the checklists were not clear in the MIMP policy for the use of the 'WHO Safe Radiology Checklist in Medical Imaging and Medical Physics' 07 January 2015, Reviewed November 2015.
- The trust's objective was that 100% of interventional procedures had a checklist completed accurately and a copy scanned into the patient records on RIS. Following an audit in March 2015, results showed that overall the directorate achieved 30% compliance for accuracy completion and having a scanned copy into the patient records on RIS. Actions to improve education and training of staff were implemented to assist in achieving the target of 100% compliance.
- The November 2015 Surgical Check list re-audit report to the clinical effectiveness committee showed improvements. Checklists scanned into the patient records on RIS was 69% compliant and of accurate completion of checklists was 70% compliant. This meant that, despite action taken in March 2015, re-audit in November identified they were still not achieving 100% compliance with safety checklist completion.
- We observed two senior members of radiology staff following trust policies and procedures to report and escalate an adult safeguarding alert; one of the sonographers had brought this to their attention.
- Staff in the one clinic told us the suicide risk among their patient group was high, and safeguarding was a high focus within the service. Staff entered safeguarding referrals on the trust's incident reporting system. They said the service had good links with the trust safeguarding lead.
- Staff said there were often cases of domestic violence and other issues. They related an example of young woman who had run to the department for protection. Staff contacted the on-site matron and found her a place of refuge. Staff reported this case as an incident.
- In the spinal injuries unit, staff told us they had good links with community safeguarding teams, reflecting the challenging problems of their patient group. Staff highlighted safeguarding issues on the electronic patient health record system.
- If staff had flagged a safeguarding risk on the electronic patient health record, then staff documented this on the patient's care pathway.

Mandatory training

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- Staff we spoke with all confirmed they were up to date with their mandatory and statutory training. The trusts mandatory training and local supervisions were completed within the departments.
- Mandatory training data submitted by the trust showed that compliance in OPD was 90% over all of the directorates. This data was not broken down by site. The lowest compliance rate for services at NGH OP was in diabetes and endocrinology (77%) and the highest rate was in urology (97%). against the trust target of 90%.
- Mandatory training compliance in pathology was 93%. We reviewed plans for ensuring pathology staff completed their mandatory training.
- In cardiac physiology and cardiac OPD, staff told us mandatory training was 100% compliant. We confirmed this by looking at the training records on screen in the department.
- The MIMP directorate report for appraisal and mandatory training compliance from 15 December 2014 to 10 December 2015 showed all specialities at all locations were achieving good compliance. For example, 95% mandatory and statutory training course compliance.
- Staff we spoke with in radiology confirmed they were up to date with their mandatory and statutory training. A number of new staff we spoke with showed us their personal induction records, which included appraisals, trust mandatory training and supervision completed within the departments.

Assessing and responding to patient risk

- The OP and radiology services assessed risks and responded appropriately in order to maintain patient safety. For example, in the plaster clinic, staff completed a risk assessment for venous thromboembolism (VTE). If staff identified a risk was then the patient was started on treatment straight away and the plaster clinic sister checked the blood results.
- The young people's diabetes service had assisted outreach services in Leeds and Harrogate.
- The pathology laboratory team had introduced a 'Patient Safety Zone' project into the inpatient wards and in the community. The aim of this initiative was to reduce labelling errors and improve patient safety. Disturbance or distraction while taking blood samples had been identified as a major risk factor for errors. Pathology staff showed us a selection of Patient Safety Zone publicity material, which including branded biro pens.
- The Sheffield Early Warning Scoring system was used to monitor the patient's condition prior to during and following radiology interventional procedures. Trust wide emergency teams were available to respond and support any medical emergencies.
- The hospital porters told us if they were transferring patients on their own and became concerned about the patient's health they took them immediately to the nearest clinical area to obtain support.
- In radiology, there was a pathway for contrast-induced nephropathy (CIN). This was available to staff on the intranet. Contrast-induced nephropathy is renal injury or impairment following injection of radiographic contrast material during a CT scan. This showed radiology had systems to monitor the risk associated with its procedures.
- Radiology protection advisors (RPAs) had good systems for monitoring radiation and protection and radiography practice within the departments.
- In radiology, we looked at two patient electronic records on the Reporting Information System (RIS) to ensure pregnancy safety checks had been completed prior to exposures being undertaken. We saw pregnancy checks completed in both records; however, we did see variations in how the different radiographers recorded checks into RIS. We brought this to the attention of the superintendent for action.
- We looked at four MRI safety checklists scanned into RIS. We saw the radiographers had not signed three of these. The patients had signed all four the checklists we reviewed. The trusts policy stated that safety checklists should be signed and dated by the patient and by the radiographer undertaking the scan.
- We looked at records on RIS for five patients who had undergone interventional radiology procedures. We were checking to ensure non-surgical intervention radiology safety checklists were completed and electronically scanned into their records. All five records included a completed safety checklist and the responsible clinician had signed them.

Nursing staffing

- There were sufficient qualified staff in the OP and radiology services to keep people safe.

- The majority of departments we visited told us their staffing was good. For example, staff in orthopaedic OPD told us there were no vacancies in the department.
- In cardiac OPD, staff told us there were no vacancies for nursing staff. There were four nurses (band five and six) and six clinical support workers. Agency staff were used to staff the extra cardiac OP clinics on Saturday mornings.
- Pathology employed around 300 staff; these included biomedical scientists and medical laboratory assistants.
- Cardiac physiology was a large department, which employed 56 physiologists. At the time of the inspection locum staff were covering vacancies. Managers explained there had been difficulty recruiting to vacant posts, due to a national shortage of suitably skilled staff.
- Sickness absence across the whole trust in May 2015 was 4.2% in line with the trust wide target of 4%. The position had improved from over 5% in January 2015.
- The trust reported that 'a workload based staffing tool was currently under development and STH was working in collaboration with external consultants to refine and test the methodology'.
- The MIMP directorate employed over 600 staff with expertise in clinical sciences and medical engineering, nuclear medicine, medical physics, nursing, administration, interventional radiology, multi imaging and diagnostics modalities for MRI, CT, fluoroscopy, cardiac, neurology and vascular angiography, breast screening, general X-ray and ultrasound.
- Radiation Protection Advisors (RPA's) and Radiation Protection Supervisors (RPS's) were employed within the MIMP directorate.
- The December 2015 MIMP staffing report showed the directorate was carrying around 26 whole time equivalent (WTE) vacancies across all specialities; recruitment to fill these vacancies was on going at the time of our visit. We found agency staff were used to maintain adequate staffing levels and skill mix within a number of radiology modalities.
- Radiology had a number of staff who rotated across hospital locations to support services. Approximately 79 WTE radiographers, 22 qualified nurses and a number of clinical imaging support staff rotated across sites.
- Staff rotas included permanently based and rotational staff. There was sufficiently qualified and unqualified radiography and nursing staff on duty to cover the capacity and demands of the imaging services we visited.
- In radiology, agency staff were occasionally used and inductions for this group of staff were completed. On the day of our visit, we saw a permanent qualified nurse inducting and mentoring one of the agency nurses in the department.

Medical staffing

- There were sufficient medical staff in the OPD and radiology services to keep people safe
- The respiratory care centre managers told us two new consultants were due to start in the respiratory group at the end of 2015. They said there were plans to recruit more secretarial staff.
- There were no vacancies in the consultant team in renal OPD; there were 10 consultants in post. Junior medical staff in renal OPD told us that consultants were approachable.
- There were no vacancies in the diabetic medical team; there eight consultant diabetologists, three of whom were academics, and three trainees in diabetes and endocrinology.
- The trust had approved posts for three additional consultant oncologists and an associate specialist in oncology; these posts were due to be advertised in the near future.
- There were around 35 consultant radiologists employed by the MIMP directorate. They covered the range of specialisms and supported the multi-disciplinary teams (MDT).
- Arrangements for on call and out of hours cover were in place.

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

Major incident awareness and training

- Major incident (MAJAX) training was part of the mandatory and statutory training programme for front line staff. The MIMP training report showed 95% of staff were compliant with their mandatory and statutory training and the OPD training report showed 90% of OP staff had completed their mandatory training. These figures were not broken down into specific outpatient areas.
- To support the trust a MAJAX plan, the MIMP directorate had developed a range of guidelines for staff to follow in

the event of a major incident. This information was accessible electronically to all staff on the MIMP shared drive and hard copies were retained within the departments.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Effectiveness was inspected but not rated. We found;

- People's care and treatment reflected relevant research and guidance, including NICE guidance.
- Staff had the skills, knowledge and experience to deliver effective care and treatment, staff were aware of the mental capacity act and deprivation of liberty safeguards legislation. Plaster technicians completed a competency pack.
- The outcomes of people's care and treatment was monitored and actions taken to make improvements. For example, the diabetes and endocrinology service had successfully reduced the number of diabetes-related foot amputations by 50% and had won awards for their foot services.
- We found excellent examples of multidisciplinary working in OPD, radiology and pathology.

However;

- In the spinal injuries unit, the main care pathway followed was the 'national spinal cord injuries pathway.' The unit was not following recommended NICE guidance for 'urinary incontinence in neurological disease' for the patients attending the unit. This meant the care and treatment of outpatients in spinal injuries did not follow current NICE guidelines. The trust was aware that the NICE guidance may not be adopted consistently and was working with directorates to understand the areas of concern to progress forward.

Evidence-based care and treatment

- People's care and treatment reflected relevant research and guidance.
- Staff in the respiratory clinic told us the service collected data for a national lung cancer audit (LUCADA) that was run by the Royal College of Physicians.
- The chest clinic contributed to research with Cancer Research UK. Staff collected tissue samples from patients who had given consent when they had a planned biopsy.
- The pain manager in the pain clinic, who was a consultant nurse specialist, told us NHS England had presented a report about the outcomes of spinal cord stimulation; these meet NICE guidance. The spinal cord implant was managed by the patients using a remote control. Staff said they had 30 patients with spinal cord stimulators.
- In spinal injuries OPD, the main care pathway followed was the 'national spinal cord injuries pathway.' One of the urology consultants told us the NICE guidance for 'urinary incontinence in neurological disease' should be followed for the patients attending the unit. There was no evidence that this NICE guidance (NICE clinical guideline 148, August 2012) was being followed in the OP care plans reviewed. When we asked senior matrons and managers about this, they confirmed that these guidelines were followed for in-patients but not for outpatients. This meant the care and treatment of outpatients in spinal injuries did not follow current NICE guidelines. The trust was aware that the NICE guidance may not be adopted consistently and was working with directorates to understand the areas of concern to progress forward.
- In radiology, we saw that policies and procedures within the directorate had been developed and referenced to NICE and Royal Colleges guidelines. These were available to all staff on the directorate's electronic shared drive.
- The MIMP directorate recognised the importance of innovation and the development of new techniques and treatments to improve patient care. For non-NICE guidance proposals, systems and processes were developed through the directorate clinical governance committee with the trusts executive group considering all the proposals. This was to ensure the proposals were appropriate, effective, and safe and the staff involved had the relevant expertise.
- Radiology reported that they had recently submitted two non-NICE proposals for consideration in relation to ethanol ablation of neck lymph nodes (a treatment for thyroid cancer) and fluoroscopically guided selective tubal cannulation (a treatment for ovarian cancer).

Pain relief

- We visited the pain clinic, which was part of the pain service. Staff in the pain clinic told us the majority of their patients had leg pain. The pain service used the WHO stage 4 analgesic ladder. The WHO pain ladder is a framework for providing symptomatic pain relief, which bases the choice of drug on the severity of pain and not the stage of disease.
- Clinical nurse specialists led the outpatient pain clinics. Pain clinic staff visited other services, such as hospices, to support palliative care patients with pain relief. This included teaching patients and carers to manage pain.
- Staff told us they were the only pain service that provided a palliative care service. They said they used intrathecal pumps for pain relief. In palliative care patients, staff used ambulatory infusion smart pumps to safely deliver medication to patients in hospital, home care and alternative care facilities. These pumps deliver medication while allowing the patient to be mobile.

Patient outcomes

- The outcomes of people's care and treatment was monitored and actions taken to make improvements.
- The diabetes and endocrinology service had successfully reduced the number of diabetes-related foot amputations by 50% and had won awards for their foot services. For example, they had won the 'best initiative in specialised services' at the national quality in care diabetes awards.
- In the pain clinic, outcomes of needle-based invasive treatments were reviewed at six and 12 weeks and entered into a database, facilitating the review of patient treatment outcomes. Pre and post interventional data for spinal cord stimulators was collated.
- In cardiac OPD, specialist nurses, cardiologists and managers attended the team meetings. We reviewed the minutes from the past 12 months and saw there was a monthly review of clinical outcomes.
- A patient in the fracture clinic told us, "I did so much damage they reckoned I would never be able to walk again. I was amazed at how much pain I was in. Now I have no pain and I am back on my bike."
- Diagnostic reference levels (DRL's) were developed as an aid to optimisation in medical exposure. IR(ME)R safety advice. Trust policy was that radiation exposures doses should be audited on a regular basis.
- As part of the MIMP directorate's on-going quality monitoring of annual dose audits, a three yearly review of DRLs was undertaken. The audits carried out in 2014 and 2015 showed the results were good when compared against the new national levels in accordance with the relevant legislation. The audit reports included the detail of any actions required.
- The MIMP directorate manager told us the service participated in the Imaging Services Accreditation Scheme (ISAS). They envisaged an application for accreditation would be made in the autumn of 2016. The manager also told us the audiology service had achieved accreditation for Quality in Physiological Services (IQIPS) scheme in October 2015.

Competent staff

- Staff had the appropriate skills, knowledge and experience to deliver safe effective care to patients. All of the staff we spoke with told us their appraisals were up to date.
- In cardiac physiology and cardiac OPD, staff told us 100% of staff had completed their appraisals. We confirmed this information by looking at the electronic appraisal records on screen.
- In pathology, 91% of staff had completed their annual appraisal and we reviewed documents, which showed there were clear plans for all those staff due to have an appraisal.
- The plaster technicians told us the staff attended a national annual 'castaways' weekend where they received training updates.
- Senior staff in pathology completed an additional senior manager training package. We reviewed the scope of this training and examples of sign-off sheets.
- Diagnostic cardiology staff had training logs for all new healthcare scientists, practitioners, support workers and apprentices. Everyone leant the same information and each section of the unit had criteria for competency.
- In respiratory OPD, nursing staff competencies included venepuncture (taking blood samples), inhaler technique assessment and education, and management of anticoagulation therapy. This supported the role of the clinical nurse specialists.
- In other OPD clinics, we found nurses were trained in advanced procedures. These included the management of supra pubic catheters, refilling intrathecal pumps and insertion of PICC lines (peripherally inserted central catheters). A PICC line is a long, thin, hollow tube that a doctor or nurse puts into a vein above the bend of the elbow. It is used to administer chemotherapy and other medicines.

Outpatients and diagnostic imaging

- There were clinical nurse specialists in a variety of services. These included cancer care, cystic fibrosis, cardiac, endocrinology, asthma, diabetes in adults, community, young people and young adult.
- Pain clinic staff had undertaken further training in pain management. This expertise was used to improve pain management in other areas; pain clinic staff provided formal and informal teaching.
- Radiology employed a full time dedicated training and development manager responsible for the co-ordination and efficient management of the recruitment, training and development programmes.
- Radiology had a high staff retention rate and encouraged role extension. As a result, many of the areas benefited from having advanced practitioners such as nurse sedationists, advanced gastro intestinal (GI) radiographers, reporting radiographers nurse specialists in nuclear medicine and nurse GI interventionist.
- We saw examples of a wide range of training and development competence programmes, which included CT vetting competencies, vascular angiography training pack, and initial competency assessment for band 5 radiographers. We observed examples of completed CT staff training records held electronically.
- Radiology provided well-established and highly regarded training programmes with Sheffield and other universities for medical staff training and development at every stage of their five year programme and for student radiographers.
- Radiology had an established faculty with many of the consultants at its core and representatives on the Royal College of Radiologist' Education Board. Staff told us that the most recent Training and Accreditation Committee recently commended the directorate for its commitment and enthusiasm.
- Radiology provided examples of the records to show who was certificated within Nuclear Medicine to administer radioactive material. 'The Administration of Radioactive Substances Advisory Committee' (ARSAC) license holders.
- The ARSAC electronic database managed by two research nurses provided monthly reviews of certificate holders, certificates held for each clinician for both diagnostic and therapeutics, serial numbers included on each certificate, which site each certificate covered for each clinician and the expiry date of each certificate.
- There were 15 qualified RPSs covering all modalities within MIMP locations. We saw evidence of their up to date training 2014 to 2015.The trust provided evidence of a competence update for one its RPS in 2015.
- The MIMP directorate had six qualified advanced reporting radiographers. The reporting practices of all six were regularly audited. We observed an example of a completed audit and saw the practitioner had to achieve the required standard of report accuracy to prove competence to practice.
- We found 92% of staff across all of the MIMP directorate's modalities had completed appraisals. As part of induction, staff were provided with a supervisor/ mentor and a training portfolio. This included evidence of supervision as part of the trust continuing professional development (CPD) programme.
- Radiology staff we spoke with confirmed the positive training and development culture and opportunities to develop advancement in practice throughout the directorate.

Multidisciplinary working

- We found excellent examples of multidisciplinary team (MDT) working in both radiology and OP services. MDT working underpinned service development and effective care delivery. For example, we observed excellent MDT working in the OPD plaster clinic. We saw good teamwork between the medical staff, nurses, support workers and plaster technicians.
- During our visit to the fracture clinic, we observed a patient with diabetes who had neuropathy and required a cast change post-surgery. The nurse wanted a podiatrist to check the healing of an ulcer on the sole of the patient's foot. A podiatrist came from another clinic to review and treat the patient while the cast was off. This allowed the patient to remain in the same area, rather than be relocated, and to get immediate attention.
- Staff in the respiratory clinic told us the lung cancer MDT met with the other MDT cancer teams once a month at the cancer forum. Staff in the chest clinic told us MDT meetings would still take place over the Christmas and New Year holiday period, in order to maintain the two-week standard.
- They explained a radiologist, histopathologist, thoracic surgeon, chest physician, clinical nurse specialist and

representatives from medical and clinical oncology attended the MDT meetings. The MDT co-ordinator took the minutes and linked by video to staff at Weston Park Hospital.
- Staff faxed information about patient tests, appointments and primary diagnosis, secondary diagnosis and treatment of patients seen in the chest clinic to their GPs on a regular basis.
- If patients needed referral because of a tumour in another body site, there was a process for quick referral to the appropriate MDT meeting.
- Staff in the pain clinic told us their MDT working included psychologists, doctors, nurses, physiotherapists, GPs and district nurses. They said maintaining a good relationship between all the healthcare staff involved was essential.
- In the diabetes centre we observed good MDT working, it was clear the team worked closely as a unit. There were direct links with the community diabetic teams and they had a base in the diabetes centre.
- There was close liaison between staff in the cardiac OPD and cardiac physiology. The heart failure service had close liaison with the community services and GPs. The physiologists worked closely with neurology, care of the elderly and the stroke/TIA service for ambulatory monitoring of all patients. Regular MDT meetings were held which allowed any issues to be raised and addressed.
- Radiologists were part of the multi-disciplinary teams and we saw examples of attendance rates for the breast and head and neck MDT meetings. The clinical director confirmed that radiologist attendance at MDT meetings was a priority.
- The MIMP directorate supported MDT working across the trust and has a well-established process to authorise non-medical staff to request radiology in compliance with legislation. Training and development was provided and the directorate retained a database of authorised users.

Seven-day services

- The fracture clinic provided a six-day service and there was a triage clinic on Sunday mornings and bank holidays.
- Renal OPD clinics were from 8am to 5pm Monday to Friday. There was no regular weekend work; however, Saturday clinics ran when triggered by workload concerns.
- Pathology provided a 24-hour seven-day service 365 days a year. Managers told us there would be 10 or 11 staff working in pathology on a Sunday.
- Cardiac physiology provided an extended working day to improve accessibility for patients. The department was open from 8am to mid-evening. Staff also worked on Saturdays and Sundays, from 8am to 5pm; staff carried out echo cardiology tests and dealt with any reporting backlogs.
- Cardiac outpatients were open five days a week from 8am to 5.30pm.
- Staff in the chest clinic told us the service always had contingency plans for bank holidays.
- Diabetes and endocrinology services ran extended clinics in the evenings and on Saturday mornings.
- The MIMP directorate provided seven-day services in MRI and core hours have extended within most modalities from 8am to 8pm. CT services are provided 24 hours seven days (24/7) a week at the Northern General Hospital and out of hours support to the stroke service at the Royal Hallamshire Hospital.
- Radiology services supported major trauma services, cardiac and vascular directorates both in and out of hours.

Access to information

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Outpatients and diagnostic imaging

- Training data submitted by the trust showed that staff in both OPD and radiology were up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke with were knowledgeable about the requirements of this legislation.
- Staff in the pain clinic told us they had procedures to follow for patients who did not have capacity. This included involving GPs, social workers, advocacy services, family and carers.
- The trust had policies and procedures in place for staff to follow to obtain consent from patients receiving diagnostic procedures. General x-ray procedures were performed using implied consent from the patient. The trusts written consent procedures were followed when performing more complex or interventional radiological procedures.
- Patients' identities were checked and confirmed against the original referral details on arrival in the department and prior to the procedure. Local guidance was in place for staff to follow if patients arriving in the department lacked capacity and where clear indications of consent and best interest decisions could not be determined.

Are outpatient and diagnostic imaging services caring?

Good

We judged the services to be good for caring because staff caring for people and their families treated them with compassion, kindness, dignity and respect. We found;

- People experienced care, treatment and support that met their needs and protected their rights.
- People understood the care and treatment choices available to them and were given appropriate information and support regarding their care or treatment.
- People received emotional support to help them cope with their care, treatment and condition. We spoke with 30 patients and two relatives; the feedback we received from all of the patients and relatives we spoke with was outstanding.

However:

- Staff did not always pull the curtains around patients in radiology and the plaster clinic.
- We observed staff remove patient's cannulas in the corridor in radiology.

Compassionate care

- Staff treated patients with compassion, kindness, dignity and respect. We observed that staff were professional, respectful and pleasant towards patients.
- We observed respectful interactions between staff and patients in both OPD and radiology. Staff showed a sensitive and supportive attitude; they were friendly, polite and courteous when caring for patients. We saw and heard staff introducing themselves to the patients and explaining the next steps in their treatment pathway.
- Patients told us, "People (staff) are really friendly", "attentive," and there were "no problems."
- Patients and relatives in the fracture clinic told us they were treated with respect and staff were friendly and polite. One relative said, "My son doesn't like hospitals but he has been okay here" and one patient said, "This place has a friendly feel."
- A higher percentage of family and friends recommended the trust than the England average between July 14 and December 14. From January 2015 to June 2015, the trust performed around the England average. In outpatients, the score for family and friends test was 94%, which is above the national average.
- In the pain clinic, we saw lots of positive feedback on the wall; there were 63 patient responses. Staff told us negative patient feedback was mainly about the clinic environment.
- In the pain clinic, we observed there was a radio in each room. Staff told us this was so patients consultations could not be overheard (as the walls were thin) and to provide patients with privacy. They said radio music also aided relaxation.
- In the spinal injuries unit, five patients told us they were very happy with their care and treatment. They told us the service was "Absolutely first rate" and that the staff "really looked after the patients". The only negative comments were about the parking.
- In the renal OPD, we noted that there was a very calm atmosphere.
- In cardiac OPD, we observed the reception staff were welcoming; this was a professional well-led clinical area.
- In the CT and MRI radiology departments, we observed that staff treated unconscious patients with respect and privacy.

Outpatients and diagnostic imaging

- The MIMP directorate reported they hosted the 'Devices for Dignity (D4D) Healthcare Co-operative'. This is a national initiative to drive forward innovative products processes and services to help people with long-term conditions.
- Radiology had carried out a patient survey in March 2015. We saw comments included: "quick service;" "I was looked after very well;" "the staff were wonderful;" "highly satisfied;" "just brilliant" and "considerate and informative."
- In radiology, the ward /departmental staff assessed whether inpatients were fit for transfer on their own or whether they required a nurse escort.
- We observed a number of mixed sex recovery bay areas used to care for inpatients prior to and following their examinations. The general x-ray inpatient bay situated adjacent to the outpatients waiting area and main reception to the department had curtains fitted to promote and maintain patient's privacy and dignity. These curtains were not routinely drawn. We brought this to the attention of the staff.
- We observed inpatients in wheel chairs and beds waiting in this area prior to and following their procedures. We saw one patient in bed having to call out for assistance as there was no member of staff monitoring the area and a call alarm was not available. There were times during the course of our visit that this area became overcrowded and space between beds and chairs was limited.
- There was a waiting and recovery bay for CT and MRI patients with curtains fitted to maintain privacy. This area included space for inserting cannulas prior to the patient's examination; this area was not in use at the time of when we visited.
- We saw two chairs situated on the main corridor outside of the CT area. Staff sat patients on these chairs for the removal of cannulas following the patient's examination. Screens were not in use to ensure the patients privacy and we saw a member of staff removing a cannula from a patients arm in full view of people using the main corridor. We brought this to the attention of the managers.
- The waiting and recovery bay in ultrasound was busy; curtains were fitted in this area but we observed these were not routinely drawn.

Understanding and involvement of patients and those close to them

- People who used the service were given appropriate information and support regarding their care or treatment. Staff told us they provided patients and their families with the information they needed, both verbally and in the written leaflets.
- In upper GI surgery OPD, we saw 'tell us what you think' and 'share your experience' posters and in the young people's diabetes clinic, we saw there was advice on exercise to manage diabetes.
- We asked three patients in the waiting area of Brearley OPD (respiratory) about information provided by the service. One said there was too much information, one said their specialist nurse gave them information and the third got additional information from their asthma nurse. They told us they had been informed about other information resources, such as the British Lung Foundation online and 'breathe easy.'
- In the young people's diabetes clinic, we observed a consultation between a young person and a consultant. The consultant treated the patient with dignity and respect the young person was enabled to make informed choices. The consultant ensured their discussions were understood by asking the young person to explain back to them.
- In plaster clinic, we heard staff giving excellent explanations and assurances to patients. The teams discussed future appointments and ensured the patients were clear about their future plans.
- Staff in plaster clinic said they aimed to give patients choice. We saw there was a good range of colours for patients to choose their cast; the plaster technician we spoke with said this "Makes it fun for patients."
- We observed a plaster technician in the fracture clinic giving care to a patient and talking with the patient. They gave an excellent explanation of how to use the newly fitted appliance. Staff invited the patient's relative to join them to watch the procedure and aid understanding. Afterwards, the patient told us how happy they were with the care they had received.
- In the respiratory clinic, we heard a call buzzer sounding; we observed staff went into the room immediately to attend to the patient who had buzzed for assistance.
- The pain clinic ran a nine-week pain management programme for patients. Staff told us this had a half-day introductory session, which had reduced the 'did not attend' rates on the course. Topics covered included

impact of pain, strategies for dealing with pain, activity, anxiety, depression, sleep and medication. The service had developed DVDs for patients to use at home, which included relaxation DVDs.
- In the pain clinic reception area, we observed a notice giving information about the nine-week pain management programme. This included information about GP referrals and spinal cord stimulation.
- Staff told us they gave questionnaires to patients before and after this course. Results showed that patients attending the course had better pain management, attainment of exercise and understanding of pain.
- We spoke with six patients in the renal OPD and five patients in cardiac physiology, they were all happy with the service and spoke highly of the care provided. One said, "Staff answered all my questions." Other comments included, "Welcoming environment," "Staff helpful" and "Impresssed."
- We heard staff talking to a patient in fluoroscopy about their procedure, which was a barium swallow. This is a moving x-ray, we heard the staff member give the patient good explanations and reassurance.

Emotional support

- Patients received emotional and psychological support to help them cope with their care, treatment or condition. For example, breast care specialist nurses provided support for patients living with breast cancer and spinal specialist nurses supported patients with spinal injuries.
- In the respiratory clinic, we saw there was a quiet waiting room for patients with a poor prognosis or special behavioural needs. We saw there was tea and coffee available in this room.
- Staff in the chest clinic told us they were trying to shorten the lung cancer pathway. They said, "Communication and meeting targets is vital but it's essential to remember the patient's needs. They may need time to reflect on their new diagnosis."
- In patients' chest clinic notes we saw there were contact names and numbers for support organisations or individuals.
- Staff told us patient bereavements were recorded on the electronic patient health record. This meant staff were aware.
- We heard plaster technicians reassuring their patients while carrying out procedures.
- We observed several instances of staff giving reassurance to patients in the renal OPD.
- When we reviewed patient notes in cardiac OPD, we saw one entry by a consultant. This documented that the patient was very worried about his referral to a heart failure clinic. As a result the consultant had taken extra time discussing this with the patient to allay their concerns." This showed staff went the extra mile to accommodate a patient who was anxious about their treatment referral.
- We observed chaperone notices on display in OPD clinic areas we visited.

Are outpatient and diagnostic imaging services responsive?

Good

We judged the responsiveness of these services to be good because services were tailored to meet the needs of individual people and were delivered in a way to ensure flexibility, choice and continuity of care. We found;

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

However:

- Space was limited in the fracture clinic and was not designed to meet the needs of patients.

- Cardiology was not meeting the 18-week performance target of 92% (target). The trust recognised this issue and there was a plan for dealing with it. There was a trust level weekly meeting with cardiology regarding waiting times.

Service planning and delivery to meet the needs of local people

- The trust planned and delivered services to meet the needs of local people. For example, there was a renal assessment unit (RAU) housed within the Sorby renal outpatient building. This was a drop-in facility for outpatients with acute kidney problems.
- On the day when we visited the RAU, we found four patients had been seen so far that day and on the day prior to our visit seven patients had been seen. We reviewed the online workbook in use by staff; we saw it had a clear audit trail and care plan.
- Patients in the fracture clinic said, "I've never been left waiting very long," "everything runs efficiently" and "I was impressed; I walked in and straight away was attended to." However, space was limited in the fracture clinic. Staff told us the fracture clinic on a Friday morning would see approximately 100 patients; approximately 30 from the triage fracture clinic and the remainder from the foot and ankle clinic. There was insufficient seating; it had nine seats and patients and their relatives had to stand. Staff told us they kept patients informed about the wait time. We asked the staff nurse in charge whether there were any plans to address this issue. They said there were, "None identified because this would be a problem for clinic times."
- When we visited this area on the Friday morning of our visit the staff nurse in charge told us there were 73 foot and ankle patients and 12 triage patients in the clinic that morning. One of the consultants in the clinic told us it was always a busy clinic but there were four or five consultants on duty to ensure good flow. When the waiting area was too crowded staff redirected patients to the triage waiting area.
- When we asked four patients waiting in the fracture clinic about the environment, one commented on the new foyer and another said the automatic doors helped a lot. However, two people felt the design of the facilities could be improved to improve patient comfort and safety. One patient, who was waiting to book in at reception said, "I feel nervous with all these people around me."
- Young people's diabetes service had a range of specialist nurses. These included podiatry, research, and community nurses. Nurses at the local university offered young people with diabetes to be seen locally and if they agreed, they were referred to the service.
- The pain clinic had a nurse-led acupuncture service. The clinical nurse specialist told us they had had to submit plans to commission it. At the time of the visit, the service was being re-established and patients had individual service funding requests.
- Radiology performed investigations for approximately 500,000 attendances per year. The directorate had a five-year strategy developed for Medical Imaging and Medical Physics.
- Staff told us that same day services were provided where practicable for CT examinations. Direct referrals were available from GPs for CT, MRI, ultrasound, fluoroscopy and other specialised imaging.
- Walk in services for x-ray plain film examinations were provided.

Access and flow

- Access and flow in the OPD and radiology departments was well established. We saw all of the departments were busy during our inspection, but patient flow was generally maintained.
- Referral to Treatment (RTT) within 18 weeks had been performing above the national average since September 2014 and the 'did not attend' (DNA) rates were significantly (25%) lower than the national average.
- However, cardiology was not meeting the 18-week performance target of 92% (target). The trust recognised this issue and had a plan for dealing with it. There was a trust level weekly meeting with cardiology regarding waiting times between the Director of Strategy and Operations and/or the Medical Director and the Clinical Director and Operations Director for cardiothoracic services.
- We saw and heard that staff in OPD clinics kept patients informed about waiting times. In upper GI surgery, the clinic was running behind and staff regularly updated patients who were waiting.

Outpatients and diagnostic imaging

- The orthopaedic OPD plaster room was adjacent to the emergency department; this ensured good patient flow. There was also an X-ray room within the department, providing easy access for patients
- In the respiratory clinic, there was electronic check in and a patient flow system, which provided data about patient waiting times within the department. This system had identified delays in the X-ray department and changes had been made to the portering system. This change had reduced the average total wait time in the lung cancer clinic from 90 minutes to 50 minutes.
- In the respiratory clinic, the care centre managers told us patient referrals for appointments were graded according to urgency. Lung cancer patients in the respiratory clinic were given faster access to CT scans. The most urgent referrals had an appointment booked within seven days. If patients do not respond to the letters then staff would phone the patients to ensure they had received them.
- Staff in the chest clinic explained the process followed if patients were not expecting a call or did not realise an appointment was being made. Multidisciplinary office staff contacted the GP to advise them the patient needed more information. They also contacted the patient to discuss times for scans and clinic appointments.
- The respiratory care centre managers told us they shared any breaches of the 18-week pathway at the monthly operational meeting. The managers said there had been no breaches reported at the meeting on the previous day.
- Staff in Brearley OPD (respiratory clinic) told us that if patients were waiting longer than an hour then staff offered a drinks trolley and toast. This was because there were no on-site café facilities. They said diabetic patients could get a food pack from the hospital kitchen. We spoke with three patients in the waiting area of Brearley OPD and they confirmed they could get drinks and toast "Whenever they needed it."
- In the spinal injuries unit, staff told us clinical nurse specialists were available for telephone advice during the working day. The five patients we spoke with confirmed this.
- Staff in the spinal injuries unit told us the service had a 'one-stop ethos.' This meant patients had an hour with the consultant, but during the same visit, they would have other investigations performed such as ultrasound and flexible cystoscopy. This ensured that when patients attended the unit time was used effectively, leading to less visits and a better patient experience.
- On the morning of our visit to renal OPD, there were four clinics running and we observed it was very busy. We spoke with six patients in the renal OPD, five said the waiting times were acceptable; one patient had waited three hours but was aware of the reason why (waiting for test results).They had been given free tea and toast while they were waiting.
- Two long-term patients commented on how the patient flow in the renal clinic had improved over the past two years. Staff told us the service improvement programme (2012-2013) had addressed flow issues within the department. A consultant explained how the processes within the department had been mapped and redesigned. This showed improvement in patient flow had been successful.
- Renal OPD staff carried out weekly monitoring of processes waiting times, waiting lists, staffing and annual leave.
- The renal OPD ran one-stop clinics; this reduced the number of visits patients made to the hospital and increased efficiency. Staff and patients told us the experience in the clinic was good. For example, staff sent blood tests for testing prior to the patients seeing the doctor.
- Staff in renal OPD told us there was a patient hotline for telephone contact in working hours. Out of hours, calls were diverted to the renal ward. Renal OPD also used telemedicine, telephone clinics, telephone communication with pre-dialysis patients and telephone triage prior to renal assessment unit review. Renal patients could also access their results online using 'Patient View'
- Cardiac physiology used telemedicine and had more than 600 patients using remote monitoring. Patients using remote monitoring included those with heart failure, intercostal drains and palpitations. Data was analysed in the department, without the need for patients to attend the hospital.
- In diagnostic cardiology, patients had heart monitors fitted on the same day as they saw the consultant or specialist nurse.

Outpatients and diagnostic imaging

- Diagnostic cardiology had a call centre, which was staffed to meet the demands of calls at peak and quiet times. The call centre was in a separate area, allowing clinic staff to treat patients without interruptions from telephone calls.
- In cardiac physiology, waiting list statistics showed no patients were currently waiting more than six weeks for their appointment. Managers scheduled additional clinics when necessary. This showed access and flow in the department was well managed.
- The diabetes clinic had a 'foot hotline.' This was available from 9am to 5pm on weekdays. On the day of our visit to the diabetes centre one of the consultants was carrying the bleep. This showed diabetes patients had direct access to consultant advice, which prevented hospital visits and admissions.
- All diabetes clinic staff were trained to carry out phlebotomy; this supported patient flow and prevented patients having to attend other departments.
- There was a Patient Tracking List (PTL) meeting to discuss individual patients care pathways. For example, waiting list managers in cardiology discussed inpatients and outpatients every Wednesday. Many of these managers knew their patients individually.
- The outpatient management group met weekly to review workload and throughput. We reviewed the minutes of the most recent meeting and saw that agenda items included waiting times in clinics, waiting list for new patients, staff numbers and staff annual leave. This group took the decisions to open clinics on Saturdays to cope with any backlogs. For example, staff in cardiac OPD told us clinics were run on Saturdays to deal with any waiting lists. We saw evidence that these clinics took place and were consultant-led.
- In cardiac physiology, staff told us that an audit of response to inpatient echo requests had led to improved flow.
- In cardiac OPD, we looked at the waiting times for all patients seen in the heart failure service in the previous two weeks. This showed all patients were seen within the target time. The targets were dependent on the patient's blood test results.
- We reviewed the outpatient's escalation policy; this documented the procedures to follow if too many patients are waiting too long.
- The pathology service dealt with 10,000 samples per day, which equated to 9.7 million tests per year. Samples came from the trust hospitals, community and GP services. The laboratory medicine centre on the NGH site was a referral centre for specialised tests from surrounding trusts.
- A team of around 14 dedicated radiology porters transferred patients between the wards and departments. This meant radiographers were in control of scheduling the times of arrival and departures of inpatients to and from the department.
- There were separate dedicated reception teams for managing inpatient and outpatient flow through the radiology department. Patients reported they did not have to wait long for their appointments. Staff arranged any further appointments prior to the patients discharge. Patients were given a choice of dates and times which suited the patient best.
- We did not observe any undue delays in radiology departments at the time of our visit. Staff told us, in the event of any delays, they kept patients informed. Inpatient examinations were performed within 24 hours to assist reductions in length of stays. The service provided walk in GP services for plain film examinations.
- The sonographers reported they had been involved in establishing and providing one-stop urology clinics.
- There was a system of 'hot reporting' for reporting A&E patient x-rays in place; results were ready within 20 minutes
- The MIMP directorate monitored turnaround times and produced a radiology report. The report for March to August 2015 showed the directorate was reporting CT, MRI and plain film reports within three days from the time of the scans. Sonographers reported ultrasound scans on the same day.
- There was a good appointments system for radiology and imaging. The service was meeting the six-week target and most patients were seen within four weeks. The service documented if patient choice took the appointment over the six-week target.

Meeting people's individual needs

- Services took account of different people's needs, including those in vulnerable circumstances, with disabilities or complex needs. There were numerous leaflets and signs available. For example, in the chest clinic, we observed an appropriate selection of leaflets were available, such as 'booking for a bronchoscopy.'

Outpatients and diagnostic imaging

- In some of the OPD clinics we visited, staff had observed the social background and habits of injured patients and had put posters in the toilets adjacent to the clinic for domestic abuse, drugs and alcohol.
- The young people's diabetes service ran a WICKED diabetes course for young people. This was a five-day course, which dealt with issues such as alcohol, drugs and sex.
- Young people's diabetes service offered one stop clinic. The service had eye screening and dietician advice within the clinic.
- In orthopaedic OPD staff held a 'foot and ankle' meeting with the remit to improve patient experience. All grades of staff attended, including consultants, nurses, clerks and schedulers.
- In respiratory clinic, staff related an incident with a young patient who required access to the sign language service and it was not available. The patient's mother told the staff about software which could be used on an electronic tablet. Staff investigated this option and, as a result, had ordered this software for future use with patients requiring a sign language interpreter.
- In the respiratory clinic, we saw the colour scheme was 'dementia-friendly.' Staff told us this had been designed and decorated in consultation with the dementia lead and link nurse, to meet dementia care recommendations. For example, there were large pictorial signs on the toilet doors.
- In cardiac physiology, staff flagged patients identified as being vulnerable on their electronic patient health record. Staff transferred this information to the referral care pathway. This meant the physiological technician was aware of the patient's dementia or learning disability when they arrived for their echocardiogram.
- Bariatric equipment, including couches, scales, hoists, chairs and toilets, were available in the respiratory clinic and the pain clinic had wheelchair accessible toilet facilities.
- In the pain clinic, we reviewed a document in the initial assessment package, which addressed ethnicity, special needs and language needs.
- We spoke with a patient who had special needs due to a genetic condition in cardiac physiology; their mother accompanied them. The patient told us they had been, "Treated with respect." Their mother told us the staff had made appropriate allowances and had addressed them directly. She said, "They do not ignore him."
- The main complaint from patients attending all of the OPD clinics was parking. The patients in the spinal injuries unit had negative comments about accessing the unit by car.
- There was a transition clinic run by renal OPD for those patients whose age fell between paediatric services and adult services. Staff told us about the 'ready, steady go' initiative to manage patient transition to adult services. They told us they held combined clinics with paediatricians. Staff told us the speed of transition depended upon the wishes of the individual patient.
- There were very well developed transition services for diabetes and cystic fibrosis patients moving from paediatric outpatient's care to adult services.
- Translation services were available for patients to request and these services were available through appointment bookings. Staff told us they were aware and knew what procedures to follow to secure the services of translators.
- Staff were able to describe how they cared for patients with memory impairments and learning disabilities. They told us they would fast track patients through the departments to reduce waiting times for these patients whenever possible.
- Staff gave patients choice for booking the location dates and times of appointments. Staff offered patients with special needs longer appointment times to ensure their additional needs could be accommodated.
- Patients we spoke with confirmed staff offered them appointments that suited their needs. Some patients confirmed that staff made appointments within two weeks of their referral; others commented that they did not have to wait a long time before they received their appointment.
- The radiology department had a radiographer justifying examination referral and managing a dedicated phone line for medical staff to use to book urgent CT, MRI and ultrasound scans. Staff offered patients referred from the memory clinics a scan on the same day.

Learning from complaints and concerns

- The provider took account of complaints and comments to improve the service. Staff we spoke with were able to describe the trust's complaints process. In upper GI surgery staff said there was 'about one complaint a month.'

Outpatients and diagnostic imaging

- Staff in orthopaedic OPD told us they received about one complaint every two months and they were usually about waiting times.
- In the respiratory clinic, staff showed us selection of thank you letters and cards. These were from patients, relatives and staff who had recently left the department.
- We spoke staff in the renal OPD who told us complaints were 'comprehensively discussed.' We saw evidence of how the service had handled a recent complaint from a renal dialysis patient.
- There were systems and processes in place to acknowledge, investigate and respond to complaints within a defined period. There was active review of complaints, and these were responded to in a timely manner across the OPD and radiology services. Complaints were discussed to share findings and identify learning outcomes at departmental and governance meetings. Minutes we reviewed confirmed this and showed that services made improvements in response to complaints submitted.

Are outpatient and diagnostic imaging services well-led?

Outstanding ☆

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

- Services had a clear vision and strategy which staff were aware of and passionate about.
- There was a well-established culture of continuous quality improvement, which was supported by robust governance, risk management and quality monitoring.
- Staff in radiology, OPD and pathology were happy and felt well-supported. There was evidence of good team working, both within and between teams, and a positive open culture.
- People who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. For example, the public were involved in a survey to improve access and flow in the foot and ankle clinic.
- There were numerous examples of innovation and improvement across all of the services inspected. For example, infection control and link worker ward won an award in 2014, The Diabetic team won the Diabetes Care award in the 2014 Health Service Journal 'Patient Safety and Care Awards' and the pathology laboratory used live screen showing the current numbers of patients awaiting urgent results in A&E.

Vision and strategy for this service

- Services had a clear vision, mission and strategy which staff were aware of and passionate about. Staff we spoke with were aware of the needs of their services and how the services planned to develop.
- The OPD service improvement programme for 2012 to 2013 had mapped all the OP processes and redesigned. Patients spontaneously commented how the flow and processes had improved. Managers were closely monitoring this at the time of the inspection.
- We observed the trust's vision was on display in OPD areas.
- The MIMP directorate had a five year strategy developed that set out a range of developments in services and technologies to improve the quality of patient care and treatments. For example;
  - growth in, and technological advancement of, cross sectional imaging
  - introduction of new imaging technologies such as breast tomosynthesis
  - The 3D imaging lab to become central to radiology workflows
  - New PACS and RIS systems.

Governance, risk management and quality measurement

- There was a well-established culture of continuous quality improvement. This was supported and assured by robust governance, risk management and quality monitoring.
- We spoke staff in the renal OPD who told us the renal unit had monthly governance meetings. We reviewed minutes of these meetings and saw that incidents and complaints were reviewed and had active action plans.
- All of the pathology laboratories were accredited with Clinical Pathology Accreditation (CPA). The pathology services were awaiting confirmation of a date for inspection by the United Kingdom Accreditation Service. There were no significant outstanding issues from the most recent CPA inspection.

- Pathology audited throughput parameters to ensure targets were met. Staff showed us there was one parameter not hitting the target value (Urea & Electrolytes test in accident and emergency). Managers had discussed this at the September 2015 quality governance meeting. They had agreed an action plan and this was being implemented at the time of the inspection. There was an agreed date for review of the audit data.
- The clinical, scientific and nursing directors together with the matron, directorate and governance managers attended the radiology directorate monthly clinical governance committee meetings. The committee routinely reviewed and monitored the directorates overall governance performance. It also routinely reviewed all incidents, complaints, claims and inquests in order to identify and monitor trends.
- The June, July and September 2015 meeting minutes included reviews with action notes recorded. Actions from previous reviews were followed up appropriately at subsequent meetings.
- All five safety sub groups reported to the Radiation Safety Steering Group (RSSG) who in turn reported to the trusts Healthcare Governance Committee and then onwards to the Board of Directors.
- The purpose of the sub groups and RSSG was to ensure radiation safety issues requiring action by the trust are reported and acted upon appropriately in order to achieve on-going legislative compliance and ensure the safety of staff, public and patients.
- The MIMP directorate employed Radiation Protection Advisors (RPA's) and Radiation Protection Supervisors (RPS's). Arrangements were in place to seek advice from the RPA's in accordance with the local rules. RPAs also supported procurement of radiology equipment, room planning, quality assurance, incident investigations and governance, radiology local rules and local risk assessments.

Leadership of service

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

Culture within the service

- Staff told us they were happy and felt supported in their roles. They also told us team working was good
- Staff were aware of the trust's PROUD values; these had been incorporated into the appraisal process for all staff. PROUD was an acronym for:-
- **P**atient first
- **R**espectful
- **O**wnership
- **U**nity
- **D**eliver
- Staff in the chest clinic told us they were proud of development of the service, involvement as a team, working relationships across the whole team. One said they said they were, "never inhibited by other team members." A member of staff in upper GI surgery OP told us it was, "A nice place to work."

Outpatients and diagnostic imaging

- We spoke with five clinical support staff in Brearley OPD (respiratory). They all praised their working conditions, team working and their manager's support.
- We observed staff in renal OPD working well together as a team and valuing each other.
- The collaborative working in pathology between the different disciplines impressed the inspection team. Although the managers were from very different scientific backgrounds, coming together in the one building had allowed co-operative working and a culture of shared learning.
- The internal reorganisation of the trusts medical imaging service was still in progress at the time of inspection. Senior managers envisaged this process was likely to continue for several months and it would take time for all the staff to adjust to the new ways of working.
- The majority of the staff we spoke with had a positive, optimistic and confident view about the recent changes introduced through the MIMP directorate and care group structure.

Public engagement

- Outpatients participated in the NHS England friends and family test (FFT).
- The renal unit involved patient representatives in their monthly directorate management meetings. These full team meetings were attended by doctors, nurses, pharmacists, dieticians, nurse specialists and one or two patients.
- The diabetes and endocrinology service had used patient feedback was as part of a Listening into Action group, which had been implemented in outpatients one.
- In response to the patient survey in respiratory OPD, staff now provided a drinks trolley. Patients were offered light lunches and drinks when they remained in the department for tests, transport home or for hospital admission.
- The respiratory OPD service encouraged the involvement of volunteers and maintained close links with respiratory support and pulmonary rehabilitation groups. These included smoking cessation groups.
- In radiology, the service sought patient opinion through the MIMP patient survey. The 2014 and 2015 survey reports showed patients were very positive and satisfied with the services provided. Managers used patient feedback in business planning.
- The outcomes from the surveys were shared with the service heads. The service agreed on focused actions, to build on to improve the quality of services provided to patients.

Staff engagement

- Staff in OPD told us that the trust's outpatient improvement programme and 'Listening into Action' groups were established within the directorate. Over 50 teams were undertaking improvement based work. Staff told us managers and senior staff asked for their ideas and solutions through local engagement.
- Staff in OPD told us there were regular monthly meetings and emails were sent to staff that could not attend.
- In radiology, the service sought patient opinion through the MIMP patient survey. The 2014 and 2015 survey reports showed patients were very positive and satisfied with the services provided. Managers used patient feedback in business planning.
- The outcomes from these surveys were shared with the service heads. The service agreed on focused actions, to further improve the quality of services provided to patients.

Innovation, improvement and sustainability

- The Sheffield Kidney Informed Patient Programme (SKIPP) was a community education programme run in Sheffield City Centre by the renal OPD. This offered information and knowledge to patients and their families.
- In laboratory medicine, we observed large screens above the bench dealing with urgent samples. It contained a full list of patients waiting for results in the emergency department. The same screens were on display in the emergency department. This meant laboratory staff could see exactly who was waiting in the emergency department and gave context and 'humanity' to the samples they were analysing. Because of the use of this management tool, results for the emergency department samples were available in one hour.
- The pathology service was leading a patient safety initiative called 'Patient Safety Zone'. This aimed to ensure the correct patient data was on the patient's sample and request form.

Outpatients and diagnostic imaging

- The directorate hosted the 'Devices for Dignity (D4D) Healthcare Co-operative'. A national initiative to drive forward innovative products processes and services to help people with long-term conditions'.
- The Devices for Dignity (D4D) Healthcare Co-operative' had been recognised with a number of awards including the 2012 Advancing Healthcare Awards: Allied Health Professionals and Healthcare Scientists Leading Together on Health.
- The development of the Sheffield 3D imaging lab is unique to the NHS and provides improved quality of scans and detail of brain tumour growth. Images could be processed quicker, in seconds rather up to an hour, saving time and money. The 3D lab was a finalist in the Yorkshire and Humber Medipex NHS Innovation awards.
- In addition to walk in services for general plain film imaging GP's can refer patients directly for CT, MRI, ultrasound, fluoroscopy and other specialised imaging examinations.
- There was a state of the art Medicines and Healthcare products Regulatory Agency (MHRA) Licenced Radiopharmacy, serving all of the trusts locations.
- Nuclear medicine staff were finalists in the Medipex NHS innovation awards 2014 after developing a new system for diagnosing debilitating digestive disorder that freed up the gamma camera, so reducing patient waiting times.
- The Diabetic team won the Diabetes Care award in the 2014 HSJ Patient Safety and Care Awards.
- A new £16 million state of the art pathology laboratory complex at the Northern General Hospital carried out 25 million tests a year.
- The pain specialist nurse led on the national pain implant group.
- The pharmacy has established an outpatient dispensary and over 3000 patients receive home-delivered drugs, delivering improved experience, information and value.

Outstanding practice and areas for improvement

Outstanding practice

- The patient care and experience delivered by staff in the Bev Stokes Day Surgery Unit particularly in relation to patients living with learning disabilities and dementia.
- The role of the duty floor anaesthetist.
- The development of a relative's room in the theatre complex.
- On GICU /GHDU there was the use of an electronic patient information system to ensure timely and accurate records, access to trust and local policies, procedures and guidelines The system ensured effective care was delivered and it was fully integrated and provided real-time information across teams and services.
- An advanced clinical pharmacy service which included a consultant pharmacist and pharmacy prescribers had been developed to improve the safety and efficacy of medicines used in critical care.
- The use of the Enhanced Recovery After Thoracic Surgery (ERAS) programme had resulted in marked improvements in the quality of care for patients on CICU.
- The laboratory team had introduced a 'Patient Safety Zone' project into the inpatient wards and in the community. The aim was to reduce labelling errors. Disturbance or distraction while taking blood samples has been identified as a major risk factor for errors. This initiative had been introduced to improve patient safety. Pathology staff showed us lots of publicity material, including branded biro pens.
- In laboratory medicine, we observed large screens above the bench dealing with urgent samples. It contained a full list of patients waiting for results in the accident and emergency (A&E) department. The same screens were on display in A&E. This meant laboratory staff could see exactly who was waiting in A&E and gave context and 'humanity' to the samples they were analysing. Urgent results for A&E samples were available in one hour because of the use of this management tool.
- Radiology provided an excellent service of 'hot reporting' for reporting x-rays for A&E patients; results were ready within 20 minutes.
- There were numerous examples where staff went out of their way to meet individual's needs. Staff demonstrated acts of kindness and flexibility to ensure patients and families suffered as little distress as possible.
- A culture of innovation and improvement was evident throughout all levels of the organisation. For example, geriatric medicine had historically been part of acute medicine but was now combined with community services. It was hoped this would help improve integrated pathways for elderly patients between acute and community services and facilitate provision of services in the community to enable elderly patients to be cared for at home whenever possible.

Areas for improvement

Action the hospital MUST take to improve

- The trust must ensure patients do not wait longer than the recommended standard for assessment and treatment in the emergency department.
- The trust must ensure that on initial assessment in the "pit stop area" in the emergency department patient's vital signs are taken and recorded consistently.
- The trust must ensure that patients in the clinical decisions unit have timely clinical reviews.
- The trust must monitor performance information to ensure 95% of patients are admitted, transferred or discharged within four hours of arrival in the emergency department.
- The trust must ensure robust escalation processes are implemented in the emergency department.
- The trust must ensure arrangements for governance within the emergency department operate effectively.
- The trust must ensure the safe storage of intravenous fluids.

Outstanding practice and areas for improvement

- The trust must ensure doctors follow policy and best practice guidance in relation to the prescription of oxygen therapy.
- The trust must ensure a strategy for end of life care is implemented.
- The trust must ensure that DNACPR records are fully completed.

Action the hospital SHOULD take to improve

- The trust should review the use of nursing care guidelines and ensure they are consistently available for all staff providing patient care, to enable accountability for care provided.
- The trust should ensure that staff have attended mandatory training in accordance with the trust target.
- The trust should improve the compliance rates for medical and nursing staff receiving an annual appraisal.
- The trust should implement plans to increase nurse staffing in the emergency department to ensure there are appropriate staffing levels at all times.
- The trust should continue to review the provision of 24 hour consultant medical cover within the emergency department as part of being a major trauma centre.
- The trust should review and implement standards of record keeping, risk assessments and the documentation of care given in the emergency department so staff have the complete information they require before carrying out care and treatment.
- The trust should continue to take action to ensure the emergency department achieve the recognised standard of 15-minute arrival by ambulance to handover to emergency department.
- The trust should review guidance in the emergency department to ensure it reflects current evidence-based guidelines.
- The trust should review the experience of patients to ensure privacy and dignity is maintained in the emergency department, particularly during busy periods.
- The trust should ensure staff follow policy and best practice guidance in relation to the administration of intravenous fluids.
- The trust should try to reduce the movement of staff to clinical areas outside of their speciality.
- The trust should introduce a robust process to share lessons learnt from incidents and mortality and morbidity reviews across directorates and care groups.
- The trust should ensure it reviews the process for the appropriate testing of all medical equipment used for patient care in the critical care units.
- The trust should ensure that there are appropriate weaning plans in place for all patients with tracheostomies and that these are made in timely way.
- The trust should consider reviewing review data collection methods and the process for submitting ICNARC data for Cardiac Intensive Care, so that patient outcomes can be benchmarked with other similar services.
- The trust should consider reviewing the critical care services in line with the Core Standards for Intensive Care Units 2013 to address areas where they are not meeting these standards.
- The trust should consider reviewing the computer provision on CICU.
- The trust should consider the implementation of the electronic patient clinical information system on CICU so there is alignment with the other critical care units.
- The trust should consider a process for obtaining patient feedback following discharge from critical care.
- The trust should monitor preferred place of care for patients at the end of life.
- The trust should review implementation of NICE urinary incontinence in neurological disease guidance for outpatients in the spinal injuries unit.
- The trust should review the fracture clinic environment to ensure meet the needs of patients.
- The trust should routinely collect waiting time information for patients waiting for appointments.
- The trust should develop standard procedures for completing interventional radiology non-surgical safety checklists for all staff to follow.
- The trust should consider undertaking regular audits of patient electronic records to ensure consistency in the completion of MRI safety checklist and pregnancy checks.
- The trust should continue to take action to reduce the number of medical outlier patients across the trust.
- The trust should continue to take action to reduce the number of bed moves patients experience during their hospital stay.
- The trust should monitor access to records in the outpatient departments.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12: Safe care and treatment Care and treatment must be provided in a safe way for service users. How it was not being met: Patients waited longer than the recommended standard for assessment and treatment in the emergency department; patient's vital signs were not taken and recorded consistently as part of the initial assessment in the "pit stop area" in the emergency department; 95% of patients were not admitted, transferred or discharged within four hours of arrival in the emergency department; patients were not clinically reviewed in CDU.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Reg. 12 (1) (g) There must be proper systems in place to ensure the safe management of medications. How it was not being met: Intravenous fluids were not always stored safely and securely, oxygen was not prescribed, drug fridge temperatures were not always accurately monitored or maintained.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Reg.17. Good Governance

Systems or processes must be established and operated effectively to :

a) assess, monitor and improve the quality and safety of services

c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided

How it was not being met:

There was no end of life care strategy. DNACPR records were not completed fully and accurately.