The Princess Alexandra Hospital NHS Trust

Inspection report

Princess Alexandra Hospital
Hamstel Road
Harlow
CM20 1QX
Tel: 01279444455
www.pah.nhs.uk

Date of inspection visit: 6 to 7 July 2021, 10 August 2021, 14 July 2021, 17 August to 6 September 2021
Date of publication: 17/11/2021

Ratings

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

Our findings

Our reports

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

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

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

Overall summary

What we found

Overall trust

We carried out an unannounced focused inspections of the following acute services at The Princess Alexandra Hospital:

- Urgent and emergency care to look at those parts of the service that did not meet legal requirements
- Medical Care (including older people's care) because we had concerns about the quality of services and to look at those part of the service that did not meet legal requirements.
- Maternity because we had concerns about the quality of services.
- We also inspected the well-led key question for the trust overall.

We did not inspect any of the other services at the trust as we did not have any information of concern and all other services were previously rated as good. Our rating of services stayed the same. We rated them as requires improvement because:

- We rated safe as requires improvement and well-led as requires improvement. Effective and responsive remained as requires improvement and caring remains as good. Well-led here is the overall trust-wide rating, not an aggregation of service ratings.
- We rated one of the trust's services as inadequate and two as requires improvement. **In rating the trust, we took into account the current ratings of the five services not inspected this time**.
- Staff did not always complete risk assessments for each patient in a timely manner. They did not always remove or minimise risks to patients. Staff did not always keep detailed and contemporaneous records of patients' care and treatment. There was inconsistent systems in place to ensure learning from incidents was shared and embedded.
- People could not always access the services they needed in a timely manner and performance in some areas was below the regional and national average.
- There were still not effective governance systems and processes in place to ensure the delivery of the strategy and quality patient care.

Our findings

However:

- Despite the challenges of the pandemic the trust continued to engage with staff, patients and their representatives and system partners in an open and transparent manner.

How we carried out the inspection

We carried out the core service inspections on various days throughout July and August 2021, with the trust wide well-led inspection undertaken in September 2021.The trust well-led inspection was carried out entirely virtually to minimise disruption and in line with our methodology due to the pandemic. We visited areas relevant to each of the core services inspected and spoke with a number of patients, staff and patient representatives.

We spoke with 105 members of staff at all levels of the organisation across all specialities and including healthcare assistants, nurses, midwives, junior doctors, pharmacy staff, consultants and administrative staff.

We also spoke with 21 patients and their relatives and six patient representatives. We observed care and reviewed 26 sets of care records. We also looked at a wide range of documents including policies, standard operating procedures, meeting minutes, action plans, risk assessments, training records and audit results.

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

Outstanding practice

We found the following outstanding practice:

- The trust's patient panel was the only model of its kind regionally. The patient's panel was a voluntary group whose main objective was to provide support for patients and their relatives/carers. The panel received funding from the trust to ensure that patients' voices were heard. The panel was awarded the Queen's Award for voluntary services in July 2021.

Areas for improvement

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

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with 17 legal requirements. This action related to trust-wide and three core services.

Trust wide

Our findings

- The trust must ensure that governance, risk and assurance systems are effective and embedded throughout the trust. (Regulation 17 (1)(2)(a)).

Urgent and emergency care

- The trust must ensure there are sufficient numbers of suitably qualified, skilled, competent and experienced nursing staff at all times to meet the needs of patients within all areas of the Emergency Department at the Princess Alexandra Hospital (Regulation 18 (1))
- The trust must operate an effective system which will ensure that every patient attending the Emergency Department at the Princess Alexandra Hospital has an initial assessment of their condition to enable staff to identify the most clinically urgent patients and to ensure they are triaged, assessed and appropriately streamlined. (Regulation 12 (1)(2)(a))
- The trust must devise a process and undertake a review of current and future patients clinical risk assessments, care planning and physiological observations, and ensure that the level of patients' needs are individualised, recorded and acted upon. This must include, but not limited to skin integrity, falls, and mental health assessments. (Regulation 12(1)(2)(a))
- The trust must ensure that it implements an effective system with the aim of ensuring all patients who present to the emergency department at the Princess Alexandra Hospital patient observations are completed within 15 minutes of arrival and as appropriately thereafter in line with trust policy. (Regulation 12 (1)(2)(a))
- The trust must ensure that the paediatric mental health room is fit for purpose and meets the standards set out in Facing the Future, Standards for Children in Emergency Care Settings. (Regulation 13 (1))
- The trust must ensure that there are safe toilet facilities for adult patients presenting with mental ill health. (Regulation 13 (1))
- The trust must ensure that there is a clear record and oversight of patients being admitted to clinical decisions unit. (Regulation 17 (1)(2)(a)).

Medical Care

- The trust must ensure that patents at risk of falls and pressure ulcers are assessed and appropriate measures are in place to ensure harm free care. (Regulation 12(1)(2)(a)).
- The trust must ensure that risk and governance processes are embedded at ward level. (Regulation 17 (1)(2)(a)).
- The trust must ensure that records of patients' care and treatment are completed with appropriate detail and contemporaneously. (Regulation 17 (1)(2)(a)).
- The trust must ensure that it has enough trained and skilled nursing and health care staff to provide care and treatment to patients, including those requiring additional supervision. (Regulation 18 (1)).
- The trust must ensure all staff complete mandatory and safeguarding training. (Regulation 18 (1)).
- The trust must ensure staff follow systems and processes to safely prescribe, administer, record and store medicines. (Regulation 12 (1)(2)(a)).

Maternity

Our findings

- The service must ensure that medical staff complete mandatory and safeguarding training and ensure compliance with the trust target. Regulation 12 (1) (2)(a)(c)
- The service must ensure a robust, embedded and audited maternity triage system with appropriate guidance and training to help keep women and babies safe. Regulation 17 (1)(2)(a)
- The service must implement an effective governance system and ensure systems to manage risk and quality performance are effective. Regulation 17 (1)(2)(a)
- The service must ensure all steps are taken to appropriately manage and maintain safe staffing in the maternity unit. Regulation 18 (1)

Action the trust SHOULD take to improve:

Urgent and Emergency Care

- The trust should ensure that they continue to improve mandatory training compliance for medical staff. (Regulation 12)
- The trust should ensure they continue to improve safeguarding training compliance for nursing and medical staff. (Regulation 13)
- The trust should ensure staff are focused complete appropriate safeguarding referrals in a timely manner. (Regulation 13)
- The trust should ensure that urgent and emergency services meet the national standard patient waiting times for treatment and arrangements to admit, treat and discharge patients (Regulation 12).
- The trust should ensure all appropriate staff are familiar with the doffing procedures for personal protective equipment in the aerosol generating procedures room. (Regulation 12)

Medical Care

- The trust should ensure that all ward areas are free from clutter and relative rooms are fit for purpose at all times. (Regulation 15).
- The trust should ensure that all ward areas display information on how to make complaints, performance data and information relevant to patients and families on health promotion. (Regulation 17).

Maternity

- The service should ensure that safety champion roles and responsibilities are clear to maternity staff and they are involved in the process. (Regulation 17)
- The service should ensure they are infection prevention control compliant. (Regulation 12)
- The service should ensure staff have access to the right equipment at the right time at important points in a woman's treatment. (Regulation 12)
- The service should consider internal security access between labour and post natal wards

Our findings

Is this organisation well-led?

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

- Leaders still did not operate effective governance processes.
- We were not assured that leaders fully understood the challenges to quality and sustainability and were identifying the right actions to address them.
- Whilst the trust had an experienced leadership team with the skills, abilities, and commitment to provide high-quality services. The board was still developing as a unitary board.
- The trust has failed to make significant improvements in specific areas which has impacted on the quality of care. This includes completion of risk assessments and maintaining contemporaneous care records.
- Not all staff were aware of the recently developed strategy and how they could contribute to the delivery.

However:

- Staff we spoke with were proud of the work they did and respected and valued each other.
- There was a strong focus on stakeholder engagement.

Leadership

Leaders had the skills and knowledge to deliver services. However, we were not assured that they had a full understanding of the challenges to sustainability and high quality care and were identifying actions to address them. The trust was working towards establishing a unitary board. Leaders worked hard to be visible and approachable for staff and provide development opportunities.

The trust board had a mix of capable new and experienced leaders including non-executive directors. There had been recent changes to the board leadership. From November 2020 to February 2021 there had been six new members of the board (executive and non-executive). The trust were also awaiting the arrival of a new chair in September 2021. This meant that whilst there were skilled leaders on the board they were yet to form into a unitary board and understand the unique qualities and needs of their team. This also increased the risk of high-quality effective board working.

There had been further changes in leadership at the trust which included a new director of midwifery and a restructure at healthcare group level to increase clinical leadership and strengthen triumvirate working. The appointment of a new director of finance had reinforced the leadership team's capacity including some improvements in financial governance. The core systems of internal control and oversight associated with these roles need to be embedded throughout the organisation. The trust had also introduced a new director of clinical quality and governance in January 2020.

Leaders did not fully understand the challenges to sustainability and high-quality care. This meant, they did not always identify actions to address them or they identified actions and were slow to implement them. For example, the trust identified the need to procure an electronic patient care record or streamlined system in 2019 to minimise risks to patient safety. A business case was only submitted in March 2021, this was agreed in September 2021 and yet to be fully implemented. The trust told us that due to the level of investment, the business case approval process was subject to regional and national review timeframes. This meant there could be further delays outside of the trust's control.

Our findings

Leaders told us that they were visible and approachable. They supported staff to develop their skills and take on more senior roles.

Our interviews with members of the board and review of documentation confirmed there were clear priorities for ensuring all executive leaders received effective support, including coaching and mentoring programmes.

The trust had a process in place to ensure that trust board members were fit and proper for the roles in line with FPPR requirements. Whilst we did not look at personnel files (due to the nature of the well-led inspection) our interviews with the head of corporate affairs and interim chair demonstrated there were effective processes in place.

Vision and Strategy

The trust had a recently updated vision for what it wanted to achieve and had launched a new strategy. The vision and strategy were focused on sustainability of services and referred to working with providers within the wider health and care economy to improve patient pathways. However, leaders and staff we spoke with did not yet fully understand and know how to apply the vision and strategy and monitor progress.

The trust had been developing their new 10 year strategy (entitled PAHT 2030) since 2019, this had been delayed due to the pandemic. The new vision, values and strategy were formally launched in September 2021. The trust told us that the vision, strategy and values had been developed through engagement with staff and system partners. However, this had been challenging due to the pandemic, particularly with staff. This was confirmed during core service inspections where staff had little or no understanding of the vision, values or strategy.

The trust's renewed vision was to be 'Modern, integrated and outstanding'. The trust's overarching strategy outlined the priorities which provided focus for achieving the vision. These were 'transforming our care, our culture, digital health, corporate transformation and our new hospital' (PAHT, 2030). There were six main supporting strategies underpinning the over-arching strategy. There was a strong focus on collaborative working both internally and externally. The trust was also due to launch their quality and patient safety strategy in November 2021. However, it was too early to say if the trust strategy was credible and realistic with clear targets, goals and oversight.

At the time of the inspection, the trust had not set up a strategic committee to have oversight of delivery of all the strategic objectives. The trust had a number of committees which fed into the board in relation to strategy. This included the new hospital committee, transformation and digital committee. Senior leaders told us they saw the board as the strategic committee. However, given the scale of the work needed to achieve the vision, the fact that the board was developing and the challenges that the organisation was currently facing; we were concerned that there was a lack of focused oversight on the key deliverables needed to ensure successful delivery of the strategy. We were concerned that reliance on the future strategy was causing delay in addressing areas of concern that impacted on patient safety such as digital transformation and estates. Our interviews with senior leaders confirmed that a strategic committee would be put in place as this was identified prior to our inspection as an area for improvement.

Whilst the strategy was in its infancy, it was focused on sustainability and working in partnership with the wider system through integrated care partnerships (ICP) and system wide planning. The trust had already started to work in line with their strategic objectives. For example, work was underway with partners in the integrated care system (ICS) to improve pathways of care for patients with mental health illness. There was an organisational development strategy in place with an action plan aligned to PAHT 2030 strategic objectives. However, senior leaders acknowledged that there was significant work yet to be undertaken to ensure the strategy was known and owned by staff.

Our findings

The trust had a medicines optimisation strategy in place which was aligned to the trust strategic objectives.

Culture

There was a mixed perspective from staff regarding feeling respected, supported and valued. Staff were focused on the needs of patients receiving care. The trust was at the start of its equality and diversity agenda and provided opportunities for career development. The trust promoted an open culture where patients, their families and staff could raise concerns without fear, however not all staff felt comfortable raising issues.

Staff we spoke with were passionate about delivering quality care and generally felt respected and supported by the trust. However, there was variable discourse in relation to staff morale. Some staff told us they were feeling burnt out and not listened to by their senior leaders. Senior leaders told us they were proud of the resilience of their staff and saddened that we heard that staff morale was low. Senior leaders acknowledged the effects of the pandemic had had a detrimental impact on staff well-being and morale.

The NHS staff survey results demonstrated the trust had been receiving similar feedback about staff well-being and morale from 2016 to 2020. The results demonstrated the trust had not made improvements in a number of areas and was worse than in previous years. The trust had developed an improvement and action plan based on the 2020 staff survey results published in March 2021. Our review of the improvement and action plan confirmed the trust had acknowledged the continued lack of improvement in some areas. It was too early to assess if the actions identified for improvement were effective.

The trust did not have a clear equality, diversity and inclusion (EDI) strategy. However, they were working as part of the integrated care system (ICS) on an ICS wide strategy. The trust's director of people was the strategic risk owner for the ICS wide strategy. They were in the process of recruiting for an EDI lead. There was an action plan in place in response to the Workforce Race Equality standards and Workforce Disability Equality standards reports for 2019. The trust also had an equality diversity and inclusion policy in place.

Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution. Senior leaders worked hard to ensure the culture encouraged openness and honesty at all levels of the organisation. There were systems in place such as 'Speaking Up' policy, disciplinary policy and Freedom To Speak Up Guardians (FTSUG) However, the trust had identified through the NHS staff survey and other sources of internal and external information that not all staff felt comfortable to raise concerns.

In line with national guidance, the trust regularly reviewed their FTSU processes. The trust assessed the FTSU function utilising NHS England and NHS Improvement self-assessment tool. The last review was undertaken in July 2021. The trust self-assessed as meeting six out of the 11 expectations for FTSU processes. Actions had been identified to address the five areas that were not met. This included recruiting a further five clinical FTSUGs, a review of disciplinary policy to ensure the trust were following best practice in principles for a 'just culture' and a review of current leadership and induction programmes.

Senior leaders told us there was a strong emphasis on the safety and well-being of staff and there were a number of processes in place to support staff. This included mental health first aiders and occupational health services. However, the NHS staff survey data and feedback from staff suggested the trust could do more. In response to this feedback, the trust worked with the local mental health trust to develop further support mechanisms

Our findings

There were systems in place to ensure that performance or behaviour inconsistent with the trust's vision and values was addressed, irrespective of seniority.

Governance

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

There were not yet effective systems and processes of accountability to support the delivery of the strategy and quality sustainable care. The trust were aware of this both through internal and external review processes. There were plans in place to strengthen governance from ward to board level.

All levels of governance and management did not yet function effectively and interact with each other appropriately. Our review of documentation and interviews with senior leaders confirmed this. There was a focus on strengthening the governance and accountability processes at Health Care Group (HCG) level. One of the first actions for HCGs was to review their accountability framework which was used at monthly performance review meetings with executive leads.

Staff at all levels were not clear about their roles and responsibilities. The trust acknowledged there was a need to define responsibilities to have clear lines of accountability. Actions had already been taken to implement and introduce Internal Professional Performance Standards to monitor and support individuals. This was due to be rolled out first in urgent and emergency care in September 2021.

Arrangements with partners and third party were in place and regularly reviewed.

Managing risks and performance

Leaders and teams did not use systems effectively to manage performance. They identified and escalated relevant risks and issues. They identified actions to reduce their impact, however these were not always effectively monitored. There was currently a strong reliance on external input to help manage performance. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The trust assurance processes were being reviewed at the time of the inspection. We were concerned that there was a lack of comprehensive assurance system to allow performance issues to be clearly escalated. The trust audit and risk management processes had not effectively identified the continued concerns we identified during this inspection.

Managers and teams used systems to monitor performance and had regular meetings to discuss performance. They identified actions to reduce escalated risks and quite often this included employing external resources to identify actions to reduce risks. In a report published in July 2021, the trust detailed the level of external support they had commissioned to help reduce risk in the organisation, particularly in relation to strategic objectives. This included external support for the urgent and emergency care division after the trust received an enforcement warning notice; however, we still found on-going concerns. The report suggested there was insufficient leadership capacity to manage the strategic objectives.

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements. This included utilising peer reviews and thematic deep dives.

Our findings

Arrangements were in place for identifying, recording and managing risks, issues and mitigating actions. However, they were not always effective, some risks we identified at core service levels were not managed effectively. Recorded risks were aligned with what staff said were on their 'worry list'. Each HCG had an individual risk register which was reviewed at regular governance meetings. The trust had a strategic risk register which was reviewed regularly at board.

The board assurance framework (BAF) was regularly reviewed at board. Our review of the BAF and associated documents demonstrated that it was used effectively based on the quality of information received.

Information management

The trust collected data and analysed it. Staff could not always find the data they needed to understand performance, make decisions and improvements. The information systems were not integrated; however, they were secure. Data or notifications were consistently submitted to external organisations as required.

There were not effective arrangements to ensure that all information used to monitor, manage and report on quality and performance was accurate, valid, reliable, timely and relevant. The trust relied on a number of different electronic and paper systems to record information related to service delivery. Not all of these systems were integrated.

The trust had recently introduced a new Chief Information Officer (CIO) in February 2021. The CIO was the lead for information management and technology (IM&T) and the trust's strategic information risk owner (SIRO). On the trust BAF and strategic risk register the lack of electronic patient record (EPR) was recorded as a high strategic risk. One of the risks associated with the lack of EPR was that the trust could not be fully assured that all information gathered for performance monitoring was accurate or reliable. Senior leaders told us there was the potential for information not to be recorded due to cumbersome systems. This could have an impact on decision-making and identifying areas for improvements. This was confirmed through our findings at core service inspections.

There was an understanding of performance, which covered and integrated people's views with information on quality, operations and finances. The trust had an integrated performance report (IPR) which was reported at ward and board level. The IPR was being reviewed to include metrics related to the strategic priorities.

Quality and sustainability both received sufficient coverage in relevant meetings at all levels.

There were a number of clear and robust service performance measures, which were reported and monitored at ward and board level. This included national targets.

Engagement

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

The trust had processes in place to gather feedback from people to help shape services and culture. This included links to equality networks both internally and externally.

The trust had a structured and systematic approach to engaging with people who use services, those close to them and their representatives.

Our findings

The trust had a well established patient's representative's group called the Patients Panel. This was established in 2013 as a recommendation from the Francis Report. This was a group of volunteers who worked for the patients of the trust and the wider community. The patient's panel was based in the grounds of the Princess Alexandra Hospital NHS trust. Our interview with members of the panel demonstrated that they were integral in engaging with a variety of stakeholders.

The patient's panel worked to organise and arrange conferences and learning events, social activities. The trust told us that the patient's panel acted as critical friends and were a conduit for the voices of patients, carers and wider community.

Our interview with the director of clinical quality and governance confirmed that the trust voluntary services delivered 'Messages to a loved one' and 'Virtual visiting' during the pandemic. The volunteer team were recently awarded an 'Unexpected Innovations' award for 2021 in relation to excellence through technology.

There was an engagement and communication strategy in place for staff. The trust had an annual engagement opportunity for staff which was called the 'Event in the tent'. This was well attended by staff and this year's event being held in September was to be the formal launch of the new strategy.

The trust had a structured approach to engaging with other stakeholders such as partners in care including regulators and commissioners.

Learning, innovation and continuous improvement

All staff were committed to continually learning and improving services. They were developing a better understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research and strived to be influences on improved patient outcomes.

The trust was enhancing their quality improvement (QI) capacity. There was an acknowledgement by the leadership team that the desired success of the strategy was reliant upon engaging with staff to develop new ways of working.

The trust had a small QI team which was led by a director of quality improvement. The trust had recognised they needed to expand QI capacity and project management capability to drive continuous improvement.

The trust had identified a number of new ways of working through having to adapt services during the first and second waves of the pandemic. Some teams told us the pandemic had galvanised the trust into implementing strategies such as virtual outpatient consultations sooner than originally planned.

The patient's panel was awarded the Queen's Award for voluntary services. This is the highest award given to volunteer groups in the UK. The award is for volunteers who provide a service that meets a need for local people, are supported, recognised and respected by the local community and the people who benefit from them and is run locally.

Staff were encouraged to make suggestions for improvement and gave examples of ideas which had been implemented.

There were organisational systems to support improvement and innovation work.

Staff were receiving training in improvement methodologies to use standard tools and methods.

Our findings

Effective systems were in place to identify and learn from unanticipated deaths. The trust had an effective mortality review process which had been developed in the last five years. The trusts HSMR and SHMI was at the lowest it had been since 2016 and was in the 'as expected' range.

Staff had time and support to consider opportunities for improvements and innovation and this led to changes.

Individual staff and teams received awards for improvements made and shared learning.

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

Month Year = Date last rating published

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement →← Nov 2021	Requires Improvement →← Nov 2021	Good →← Nov 2021	Requires Improvement →← Nov 2021	Requires Improvement ↓ Nov 2021	Requires Improvement →← Nov 2021

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

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
The Princess Alexandra Hospital	Requires Improvement ➔➔ Nov 2021	Requires Improvement ➔➔ Nov 2021	Good ➔➔ Nov 2021	Requires Improvement ➔➔ Nov 2021	Requires Improvement ➔➔ Nov 2021	Requires Improvement ➔➔ Nov 2021
Overall trust	Requires Improvement ➔➔ Nov 2021	Requires Improvement ➔➔ Nov 2021	Good ➔➔ Nov 2021	Requires Improvement ➔➔ Nov 2021	Requires Improvement ➔ Nov 2021	Requires Improvement ➔➔ Nov 2021

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

Rating for The Princess Alexandra Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ➔➔ Nov 2021	Requires improvement Jul 2019	Good Jul 2019	Good Jul 2019	Requires Improvement ➔➔ Nov 2021	Requires Improvement ➔➔ Nov 2021
Services for children & young people	Good Jul 2019	Good Jul 2019	Outstanding Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019
Critical care	Good Mar 2018	Good Mar 2018	Good Mar 2018	Requires improvement Mar 2018	Good Mar 2018	Good Mar 2018
End of life care	Good Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019
Outpatients and diagnostic imaging	Good Oct 2016	Not rated	Good Oct 2016	Requires improvement Oct 2016	Good Oct 2016	Good Oct 2016
Surgery	Requires improvement Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019
Urgent and emergency services	Inadequate ➔ Nov 2021	Good Mar 2020	Good Mar 2020	Requires Improvement ➔➔ Nov 2021	Inadequate ➔ Nov 2021	Inadequate ➔ Nov 2021
Maternity	Requires Improvement ➔➔ Nov 2021	Requires Improvement ➔➔ Nov 2021	Good Jul 2019	Good Jul 2019	Requires Improvement ➔➔ Nov 2021	Requires Improvement ➔➔ Nov 2021
Overall	Requires Improvement ➔➔ Nov 2021	Requires Improvement ➔➔ Nov 2021	Good ➔➔ Nov 2021	Requires Improvement ➔➔ Nov 2021	Requires Improvement ➔➔ Nov 2021	Requires Improvement ➔➔ Nov 2021

The Princess Alexandra Hospital

Hamstel Road
Harlow
CM20 1QX
Tel: 01279827844
www.pah.nhs.uk

Description of this hospital

The Princess Alexandra Hospital NHS Trust provides a comprehensive range of acute and specialist services. The main site is the Princess Alexandra Hospital (PAH), which is a district general hospital. There are also three smaller satellite sites where services are also provided. These are, Herts and Essex Hospital, Rectory clinic and St Margaret's Hospital.

The trust has 414 acute inpatient beds, 10 critical care beds and 64 maternity beds and employs around 3184 full time equivalent staff across the sites. Of these staff, 778 are nurses, 455 are medical staff and 1951 are classified as other staff. (Data taken from Insight 8 April 2020).

The main hospital is located in Harlow, Essex and provides acute and specialist services to a population of around 350,000 people from the West Essex and Hertfordshire region, within the area of Harlow, Epping, Uttlesford, Bishops Stortford and Loughton. Outlying clinics are based in Bishops Stortford, Loughton and Epping. Harlow is on the border between Essex and Hertfordshire and the Trust is commissioned by two CCG's, NHS West Essex CCG and NHS East and North Hertfordshire CCG.

The Princess Alexandra Hospital was built in the mid 1960's, and the building is showing very significant signs of age with a backlog of maintenance and there is very little room for expansion on the current site. The trust is part of the nationally led New Hospitals Programme and the Government announced it is to receive funding to rebuild a new hospital in Harlow.

The trust had experienced significant challenges over the past 18 months due to the COVID-19 pandemic. At the peaks of the COVID-19 pandemic critical care bed capacity was severely impacted, resources were significantly strained, there were several staff admissions and three staff members who passed away due to COVID-19. As of 1 August 2021, the trust had treated over 2,264 COVID-19 positive patients, of those 515 were COVID-19 related deaths. Staff were redeployed from substantive roles to care for the most acutely ill patients and support staff in critical areas. Services had to be redesigned and moved at short notice. The trust is recovering services through local action and regional support.

Medical care (including older people's care)

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

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

Mandatory Training

The service provided mandatory training in key skills; however, not all medical staff had completed it.

Nursing staff received and kept up to date with their mandatory training. Data supplied by the trust following our inspection showed nursing staff achieved above the trusts 90% compliance target. However, medical staff failed to achieve 90% compliance for all mandatory training.

The mandatory training was comprehensive and met the needs of patients and staff. Staff we spoke with explained that the trust offered a wide range of training, however some of this had been restricted due to COVID-19. New staff we spoke with said the trust provided ongoing support and guidance and that induction training met their needs.

Clinical staff completed training on recognising and responding to patients with learning disabilities and dementia. However, medical staff achieved 74% compliance with dementia training and 71% compliance with learning disability training, both below the trust compliance target of 90%. Nursing staff achieved 91% training compliance.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training records were centralised, managers had oversight of staff training records and knew when staff required refresher training.

Safeguarding

Medical staff training on how to recognise and report abuse was below the trust's compliance target.

Nursing and medical staff received training specific for their role on how to recognise and report abuse. Data provided by the trust following our inspection showed nursing staff achieved 89% compliance with safeguarding adults level 2 and medical staff achieved 54%. Both were below the trust compliance target of 95% and showed a fall in compliance from our last inspection in 2019. Data supplied for level three adult safeguarding showed that medical and nursing staff did not achieve the 95% compliance rate, this training also included mental capacity act training.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we spoke with gave examples of the type of abuse they may see, for example domestic violence, female genital mutilation (FGM) and financial abuse.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with knew the trust safeguarding lead.

Medical care (including older people's care)

Staff followed safe procedures for children visiting the ward. At the time of our inspection, visitors were asked to sign a visitors' book on the ward and wards were protected by buzzer and locked door systems to prevent non-authorized entry.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were visibly clean and well-maintained. We observed staff following the trusts infection prevention and control (IPC) policy.

The service generally performed well for cleanliness. Between April and June 2021, the trust consistently achieved above 95% compliance with hand hygiene audits within the medicine wards.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We spoke with two domestic staff during our inspection and found they followed cleaning schedules on a day-to-day basis.

The trust had identified ward areas specifically for the care and treatment of COVID-19 positive patients, these were separate areas and had additional controls regarding PPE and infection control.

Staff followed infection control principles including the use of personal protective equipment (PPE). The service had a plentiful supply of PPE and staff adhered to the trusts policy when supporting patients, including wearing masks, aprons, gloves and face shields / goggles where necessary. Hand sanitiser and washing facilities were available on all wards, signage advised staff and visitors to follow infection control practices, when entering and leaving ward areas.

Between July 2020 and June 2021, the service had no cases of MRSA Methicillin-resistant Staphylococcus aureus (MRSA). MRSA is a type of bacteria that's resistant to several widely used antibiotics. This means infections with MRSA can be harder to treat than other bacterial infections. The service had 26 cases of Clostridium difficile (C.difficile). C.difficile is a bacterium that can infect the bowel and cause diarrhoea. The infection most commonly affects people who have recently been treated with antibiotics. It can spread easily to others. The service had five cases of methicillin-susceptible Staphylococcus aureus (MSSA). MSSA is also known as Staph infections, which are caused by bacteria called staphylococcus. They most often affect the skin. They can go away on their own, but sometimes they need to be treated with antibiotics. To add context to the information above, due to the number of ward moves in response to the COVID-19 pandemic not all wards were in the medicine healthcare in the 12 months prior to our inspection.

The service had eight cases of Escherichia coli (E. coli), which is a type of bacteria common in human and animal intestines, and forms part of the normal gut flora (the bacteria that exist in the bowel). There are a number of different types of E. coli and while the majority are harmless some can cause serious food poisoning and serious infection.

Staff cleaned equipment after patient contact and labelled equipment with "I am clean stickers" to show when it was last cleaned. We observed staff cleaning equipment prior to and after use by patients.

The endoscopy service decontaminated reusable equipment in line with national guidance and was following the guidance outlined in the management and decontamination of flexible endoscopes health technical memorandum (HTM).

We did identify that some equipment used for administration of medicines had not been cleaned and one member of staff was not bare below the elbows, but the manager spoke to the staff and dealt with this issue.

Environment and equipment

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

At the time of our inspection the trust was in the process of recovery due to environmental changes to manage the COVID-19 pandemic. For example, Ray ward had changed provisions from COVID-19 to post-surgery and services were delivered on Saunders ward. Winter ward was closed for refurbishment and Gibberd ward was closed by the trust because of concerns around patient safety. One ward, Tye green, remained unchanged but had a mix of post-surgery and medicine patients. The new older peoples' assessment and liaison (OPAL) area was open to take patients directly from the urgent & emergency care area and provide services for the frail or elderly.

The service didn't have suitable facilities to meet the needs of patients' families. We found the relatives room on Harold ward to be visibly cluttered and storing equipment that would ideally have been in a storeroom. Additional wards were cluttered, had equipment from other wards, and were visibly untidy, staff told us this was due to the change in environments and work in progress.

The trust told us that wards being refurbished would have non-slip floor and more rails in bathrooms as part of the falls strategy and improving the environment for patients living with dementia. The trust was reviewing toilets on some wards' and moving toilet roll holders closer, providing handrails along corridors and ergonomic design around the bed space. The trust planned to have dementia colours on one ward and to have a yellow track on the floor showing the way to bathrooms. The trust was considering improving lighting, providing dimmed lights at night and beds with lighting on the side.

Patients could reach call bells and staff responded quickly when called. We observed that staff used the call bell system and that patients had these within reach when necessary.

Staff carried out daily safety checks of specialist equipment. We reviewed the resuscitation and airways trolleys on medical wards and found these to be checked and tagged at all times. The trolleys had a system in place to prevent the equipment and medicines from being tampered with in line with the Resuscitation Council (UKs) guidance that all resuscitation medicines must be stored in tamper-proof containers.

The service had enough suitable equipment to help them to safely care for patients. We checked 22 items of equipment including air flow mattresses, scopes, stands and hoists amongst others and found these all within service date. We also checked 55 consumable items and found these to be stored safely and within their expiry date.

Staff disposed of clinical waste safely. Staff followed appropriate processes to manage clinical waste including sharps bins, which were dated and sealed and macerators to hold or destroy clinical waste.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient and remove or minimise risks.

Medical care (including older people's care)

Staff had a range of risk patient risk assessments for patients on admission. Risk assessments included falls risk assessment and care bundle, pressure ulcers, nutrition and hydration and also assessment of patient behaviour where appropriate, for example cognitive impairment or behaviour likely to cause harm to the patient or others. We identified concerns in relation to the completion and management of the falls risk assessment and care bundle and the ongoing management of patients at risk of falls within the service. Staff had not effectively recorded the risks and records showed staff had either not completed the check lists, or the risks had been wrongly categorised.

We reviewed nine patient records and specifically tracked five patients records in relation to their falls risk assessment and care bundle and pressure care. We found errors in the five patient records where staff had recorded the falls risk assessment and care bundle incorrectly; for example, rating the patient as high risk of falls and then recording actions as medium or low risk. One patient record showed the risk assessment for pressure care was not completed correctly. The trust had a Pressure Ulcer Strategy 2021-2022, this was in its early stages with nine actions still under review and four actions completed at the time of our inspection.

One of the actions on the falls risk assessment and care bundle was to provide patients or relatives with a falls leaflet. We could not see any leaflets on display, staff did however print two information sheets for inspectors one titled preventing falls whilst in hospital and another titled eye health and falls. Staff told us that leaflets and information had been limited on wards due to infection control and COVID-19 controls.

The trust had one member of staff who acted as the falls lead, the wards had no falls champions at the time of our inspection but were developing these as part of the trust's annual Strategic Falls Prevention Plan 2021/22. Ward-based matrons supported staff with falls reviews, but staff told us actions due to COVID-19 had made it more difficult to manage the falls process. Staff told us the trust were finalising the falls strategy for this year and aimed to reduce the number of falls by 50%, the trust reported 321 falls with harm in 2021. However, staff told us the falls rate was clouded because reporting of falls on the trust's electronic incident system wasn't as clear as it should be, and staff were trying to make this process clearer. Falls data was inclusive of all falls including faint and collapse episodes. Managers told us that in the 12 months prior to our inspection, most wards had moved around, so it had been difficult to benchmark falls data. The trust acknowledged that there had been challenges during the pandemic to ensure that all staff had the appropriate falls training. However, there was an action plan in place to address this. This included refresher training, dedicated support to wards, monthly audits and the review of live cases with members of staff.

Managers we spoke with told us they had implemented a new risk assessment and care plan for enhanced care, which included additional documentation for staff to complete where enhanced patient risks or concerns were identified. In one of the records we noted that staff had recorded an initial assessment of the patient, however this should have been completed within six hours of admission or reviewed within 12 hours or when the patient's condition changed. Staff had not made any additional entries into the record and we were not assured the patient had received an ongoing review or if the risks had been managed. Another patient record showed that staff had recorded challenging or threatening behaviour, we could find no follow up details or actions taken as a result of the staff raising this concern. At the time of our inspection, the trust was in the process of implementing a dedicated enhanced care team. This team was being introduced to support wards with undertaking the newly implemented enhanced care plans and assessments. Our interviews with senior leaders confirmed that this team was in its early stages and that there were already plans in place to improve some of the areas of concern that were identified during inspection.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. This was accessible via an on-call telephone service. Staff we spoke with told us that the service was responsive to their needs and that they could also access psychiatry support for patients with dementia or challenging behaviour.

Medical care (including older people's care)

Shift changes and handovers included all necessary key information to keep patients safe and appropriate information regarding patient needs, plans for discharge and ongoing care.

The electronic handheld IT tablets enabled staff to flag patients who may be living with dementia, learning disability, nutritional needs and a falls risk assessment and care bundle amongst other risk issues. This was a colour coded system, showing the risk rating as red or high risk, amber for medium risk or green for low risk. Staff could identify which patients required additional support. However, we were concerned that information on the handheld IT tablets didn't always match with the patients written records or actions taken in some of the records we reviewed. The issue of patient records was understood and recognized as a risk by the trust.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used a nationally recognised tool to identify deteriorating patients. The trust used the national early warning score system (NEWS2) for adults. Nursing staff completed patient observations on handheld IT tablets. The tablets provided the staff, the ward manager and matron with an overview of patients NEWS2 scores. In addition, if a patient was triggering on their NEWS2, this alerted the critical care outreach team (CCOT) who were able to take appropriate action in accordance with the patient's observations. The CCOT were available onsite 24 hours a day, seven days a week and staff had access to Hospital at Night for additional support. Hospital at Night is a multidisciplinary team-based approach to providing safe and effective patient centred care to patients overnight.

Staff we spoke with told us they used the sepsis six bundle for any patient who may trigger a high NEWS2 score and showed associated sepsis signs. We did not see any patients with sepsis during our inspection, so were unable to track any patients on the sepsis six bundle.

The trust conducted patient Venous Thromboembolism (VTE) assessments on admission. VTE is a condition where a blood clot forms in a vein. The operational standard outlined in the NHS standard contract is that 95% of inpatients aged 16 and over are risk assessed for VTE on admission each month. Data supplied by the trusts following our inspection showed that the trust achieved above the 95% operational standard consistently between June 2020 and May 2021.

Nurse staffing

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

The service did not have enough nursing and support staff to keep patients safe. Some of the wards we visited during our inspection did not have enough nursing and support staff to maintain patient safety and support.

In May and June 2021, the medicine HCG nurse vacancy target was below the target of 8% when the 35 international nurses who had not finalised on the trusts employee records system to reflect their allocation after completion of theirobjective structured clinical examination (OSCE) were included. The vacancy rate for medicine in May was 1% and June 1.2% and the overall trust nurse vacancy rate in May was 4.8% and in June it was 4.6%.

The service had increasing turnover rates. In June 2021, the turnover rate for registered nurses was 11.81%, this rate had increased monthly from 8.82% in January 2021 but remained below the trusts target of 12%.

The trust set a staff sickness absence rate of 3.70%. Between July 2020 and June 2021, the trust achieved below this target on three occasions in September and October 2020 and again in March 2021. The trust failed to achieve below the 3.70% for the other months during this time, however there was significant impact on staff sickness due to the COVID-19 pandemic.

The service had increased rates of bank and agency nurses used on the wards from July 2020 until June 2021.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Data provided by the trust following our inspection showed that on 6 July 2021, four wards were flagging as green, one as amber and three red. The trust stated that following professional judgement by the matron, one ward was not short staffed on 6 July and five wards were green, three amber and one red.

The ward matrons collected data from all ward areas and held an 11am staffing huddle with the director or deputy director of nursing daily, except at weekends. The trust used a safer staffing tool to identify staffing levels, patient acuity and support decisions on how to allocate staff including support for patients who are rated as amber, red for falls risks or critical.

The ward manager could adjust daily staffing levels according to the needs of patients. Managers we spoke with told us that staffing issues at the time of our inspection were because the ward did not follow process and there was no mitigation of risk. A safety huddle didn't happen on the day of our visit to Harold ward, which usually occurs ahead of the input of safer staffing figures into the safer staffing tool.

The trust carried out a review of ward staff establishment every six months. Managers informed us after our inspection that Harold and Tye Green ward would receive additional shifts.

Agency staff were known to the trust, and the same staff covered wards every week.

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

Medical staffing

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

The service had enough medical staff to keep patients safe and the medical staff matched the planned number. The trust had a template rota to cover all ward areas. If there was a concern, for example during higher levels of COVID-19, rota coordinators and managers worked together to manage medical staff allocation on wards. At the time of our inspection there was extra medical cover overnight for COVID-19 wards. If there was a need for extraordinary cover, this was flagged to the associate medical director who liaised with the manager and coordinators to agree medical staff allocation. The trust had a business case going through the trust board to provide an additional degree of medical cover that will mean an increase in medical staff recruitment.

The service had a reducing vacancy rate for medical staff. In July 2020, the vacancy rate for medical staff was 16.2%. This had reduced on a monthly basis throughout the remainder of the year to 7.7% in May 2021.

Medical care (including older people's care)

The service had reducing turnover rates for medical staff. Between July 2020 and April 2021, turnover rates reduced from 14.3% to 10.3%, rising slightly to 11.2% in May 2021.

Sickness rates for medical staff increased from 3.2% in July 2020 to 4.5% in December 2020. In January 2021 the sickness rate increased to 4.9% and then reduced between February and April to 3.7% and increased again in May to 4.7%.

The service had reducing rates of bank and locum staff. Between July 2020 and May 2021 bank and locum usage had reduced from 12.1% to 4.6%.

The service always had a consultant on call during evenings and weekends. Out of hours, the medical staff rota was put together by managers and trust's rota coordinators, with a mix of medical specialties. The rota coordinators were responsible for looking at all of the medical workforce, consultants, registrars, junior doctors and then allocating the rota based on roles and responsibilities.

In January 2021, the proportion of consultant staff reported to be working at the trust was slightly lower than the England average and the proportion of junior (foundation year 1-2) staff was slightly higher than as the England average.

Records

Staff did not keep detailed records of patients' care and treatment. Records were not always clear, up-to-date or stored securely.

At the start of our inspection, we were told by senior staff that the trust was in the process of reviewing and integrating patient information due to information being stored in different formats and in different places. We found the process of tracking patient records to be difficult and labour intensive. Information regarding patient care and treatment was stored in both paper and electronic format and we weren't assured these systems worked with each other in order to maintain patient safety. We identified and shared our concerns with managers regarding staff not completing falls risk assessments appropriately, as well as the enhanced care record and lack of follow up on behavioural charts for patients with complex needs. The enhanced care policy and process was launched on the day of the inspection. Training and support for staff was part of the roll out. The implementation plan including ongoing training for staff supported by the lead nurse for falls prevention and matrons.Training was scheduled for the week of 12 July 2021 for all staff who provided enhanced care.

Managers we spoke with told us the trust was procuring an electronic patient record management system, where all patient records would be in one place, but had no implementation date for the new system.

Patient written records were not stored securely, the staff had made changes on the wards based on infection control guidance and we found paper records stored in wipeable folders, outside patient rooms. Clinical notes were stored in locked cabinets and electronic notes were accessible on a handheld electronic tablet, desk-based computers and workstations on wheels which were locked when not in use. Staff we spoke with told us that restricted visiting had been in place, and that patient records had not been an issue, but now wards were reopening to visitors the storage of records would be reviewed.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

Medical care (including older people's care)

Staff did not always follow systems and processes when prescribing, administering and recording and storing medicines. The service used an electronic system for the prescribing and administration of medicines in line with the current provider's policy. Some medicines were not stored in original packaging and loose strips were found within medicine trolleys. Some medicines were either out of date or had no batch or expiry number on the packaging to know whether they were suitable for use.

Keypad entry numbers to areas where medicines were stored were not changed regularly to ensure only authorised staff had access. Refrigerators were recorded as being out of range for consecutive days with no action taken to ensure the medicines were safe to use. Stocks of medicines being stored on the ward were not reviewed regularly and did not always reflect the needs of the patients on that ward.

Staff knew how to access medicines in an emergency. There was a list of critical medicines (medicines that should not be omitted) displayed on wards but there was not always good knowledge about what constitutes a critical medicine.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. There was a clear discharge checklist in place and staff counselled patients about their medicines before going home.

Staff followed current national practice/guidance to check people had the correct medicines. Pharmacists received a detailed handover report so they could target those admitted to hospital on high risk medicines or those that required greater monitoring.

Staff knew how to report medicines incidents, they received feedback and were aware of actions taken following investigations. The service provided safety bulletins with regards to the safe use of medicines which were shared with staff.

On Lister ward staff had looked at the impact of de-prescribing in the elderly population (reducing the amount of medicines taken). We saw a screening tool used to identify potentially inappropriate prescriptions. There had been a significant decrease in the amount of medicines prescribed for people during this pilot. Whether this influenced admission rates or rates of falls was being examined. Staff were looking to roll this out to other wards.

Incidents

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

All staff knew what incidents to report and how to report them. Staff we spoke with during the inspection knew the trust's incident reporting systems and how to report incidents via an online system.

At the time of our inspection, the service had no never events on any wards.

Data supplied following our inspection showed the medical health care group (MHCG) had four open serious incidents (SI) and one open SI relating to COVID deaths which was part of a cluster of 40. Serious Incidents were investigated by the MHCG clinical teams with support from the senior team throughout the investigation.

SI reports were subject to a review and approval process within the MHCG prior to being submitted to the trust's serious incident assurance panel (SIAP) for further review and approval to submit to the local service commissioners. The 40 SI in relation to hospital onset COVID 19 deaths were reported as individual serious incidents as per the National requirement. The trust told us all cases were reviewed individually, however, a single investigation (cluster) report had been completed to include all of these SI and was going through the final review and approval process by the trust prior to submission to the CCG. The investigation of these cases was carried out by the trusts mortality matron and supported by the trust's patient safety and quality team.

Two SI were related to falls with patient's sustaining head injuries. Both cases are subject to coroners' inquests which have been scheduled. One of the investigation reports is due to be reviewed at the SIAP for approval for submission to the local commissioners. The second investigation report was under review for completion by the MHCG. The trust told us that learning from the investigation had been shared with the ward teams. Senior leaders told us that the learning from falls incidents was integrated into the falls strategy which was now being regularly reviewed. The learning included reviews of staffing levels and skill mix, the new enhanced care policy and falls risk assessments.

Staff we spoke with understood and knew the importance of the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us they found out about incidents through emails and feedback from the managers on the ward. The staff accessed the trust's intranet where shared learning, newsletters and updates were available.

Safety Thermometer

We were not assured that staff effectively used systems and processes to maintain and improve patient well-being.

The service monitored safety performance. However, during our inspection we identified gaps in patient records in relation to the management of falls and pressure care and were not assured that patient safety was being audited effectively in order to maintain and improve their well-being.

Trust board papers stated there were a total of 46 patient pressure ulcers (PU) in April 2021. Of those 46 PU's, a total of 38 patients were injured, meaning six patients sustained more than one pressure ulcer during admission. Four were moderate harms, one category four was an intensive care patient (ITU) patient, and the remaining were minor harms. Four pressure ulcers were medical device related, attributable to oxygen devices and stockings.

Trust board papers from April 2021, stated the highest number of hospitals acquired pressure ulcers were from Tye Green with ten pressure ulcers in total. During our inspection, Tye Green ward displayed data showing that six patients had fallen in June 2021, and 12 patient pressure ulcers were reported on the ward during the same period.

The trust was undertaking audits on wards that had the highest incidences on a weekly basis, in order to identify gaps in care and work with ward managers, matrons and practice development team for action plans.

Medical care (including older people's care)

Is the service well-led?

Requires Improvement 

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

Leadership

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

There was an established leadership structure within the medical health care group (MHCG). This included a divisional director, associate director of nursing, head of nursing, matrons and ward managers. Staff we spoke with told us the management team were supportive and visible within the wards.

Leaders understood the challenges to quality and sustainability, and they identified the actions needed to address them. The trust had implemented a new falls strategy and identified a staff lead for falls management across the medical services. However, this strategy was yet to be fully implemented and embedded. Data supplied by the trust following our inspection showed the rate of falls was declining; however, we were also aware that there were some concerns about the quality of falls data which was being addressed.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff did not fully understand and know how to apply them and monitor progress. During our inspection we didn't see any information for the vision or values of the trust displayed on the wards we visited.

Staff we spoke with had limited understanding of the trusts vision and values. Managers we spoke with told us that sharing this had been a challenge due to COVID-19; deep cleaning meant removal of display boards and materials. Managers told us the trust magazine would be going back into print in addition to electronic communications to all staff. Managers provided daily updates, staff briefings occurred on Tuesdays, and screensavers with rotating information were accessible for all staff.

Culture

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

Staff we spoke with felt respected and valued. They described the COVID pandemic as being a major challenge and the culture had been based on working together to respond to the demand.

Medical care (including older people's care)

Staff we spoke with were physically tired and emotionally drained. The trust was recruiting new staff and supporting overseas staff into the day-to-day work schedule. However, staff described not having enough staff or trained staff as being normal and this was affecting their ability to meet patient needs and left them feeling frustrated.

Governance

The trust had governance processes in place however we were not assured these were embedded at ward level.

The MHCG had established governance processes, however we were not assured these were embedded at ward level. The ward manager, matron, associate director of nursing, head of nursing and patient safety and quality team (PSQT) held incident huddles daily. Ward safety huddles happened twice daily, seven days a week and the ward matron and head of nursing met weekly. We did not see any safety huddles during our inspection, however the trust provided records from safety huddles which showed staff discussed patient risk, incidents, staffing equipment checklists amongst other key details.

We reviewed governance meeting records from 20 April, 18 May and 15 June 2021. Topics covered included risk, incident reporting, staffing levels, performance and staffing. Clear actions, lead staff and time scales were set in the minutes including feedback from previous meeting actions. However, given the level of governance and perceived oversight of risk, we were not assured that this was being translated to ward level, as we had identified failings in record keeping and the management of risk which could have led to patient harm. Managers told us they were looking to translate governance meetings to service level, with mini board meetings to ensure governance won't be a top-down issue.

The trust told us that medicine specialties had been unable to undertake mortality and morbidity meetings due to a lack of capacity. The trust had a mortality improvement plan in place to review learning from deaths and to make the process more robust and share learning to reduce similar deaths.

All deaths within the trust were reviewed by an independent medical examiner to identify the cause of death after discussion with the treating teams and liaison with the family should there be any concerns raised. They also put cases forward for Structured Judgement Reviews (SJR's).

A monthly service review for medicine fed into the monthly patient safety and quality group, then into the health care group board and performance review meeting. Bi-weekly medical establishment and finance meetings also fed into the health care group board.

Management of risk, issues and performance

The trust had risk processes in place, however we were not assured these were embedded at ward level.

Each ward had a dedicated risk register. Initial concerns regarding risks came from ward staff including staffing, falls, environment and these were discussed with matrons and the PSQT before being added to the risk register. The risk register was discussed at board meetings and then went to business meetings and other senior meetings.

Managers we spoke with told us that morning ward meetings included a safety huddle to review incidents from the previous day. However, we didn't observe any safety huddles during our inspection and on Harold ward the safety huddle didn't take place due to other staff priorities and the manager was unavailable. Information from the safety huddles went to the ward matrons, ward managers then the PSQT.

The risk register included staff ensuring all patients admitted to a ward were assessed and care plans put in place to minimize the risk of falls. During our inspection, we identified that staff did not complete or had not rated falls risk assessments correctly. The risk register identified that staff should be using perfect ward rounds to audit this activity, no evidence of this was on display within the ward areas and the risk register stated there were gaps in compliance with the perfect ward.

Whilst the trust reported a reduction in falls and were reviewing the method of reporting and categorising pressure ulcers, we still found that staff were not completing fundamental risk assessments that would prevent patient harm on a day- to-day basis. The trust was last inspected in July 2019 and was given specific requirements to ensure that detailed risk assessments and care plans were in place for patient falls and pressure care. Management of risk, issues and performance remained an area that required improvement.

Engagement

Leaders and staff actively and openly engaged with staff.

Ward managers engaged with their staff using different methods including team meetings, ward newsletters, away days and using closed social media groups.

The service held a Tuesday morning brief where the executive team gathered in the cafeteria to brief staff on developments within the trust and provided staff with an opportunity to feedback information to the executive team and trust colleagues.

The trust's 2020 staff survey highlighted a higher score for staff that had been abused by patients and the trust were planning training in de-escalation for staff. The survey also showed the trust scored an average of 6.8 out of 10 for staff engagement, against the average score of 7 out of ten.

The staff survey had also led to additional training for matrons and band seven ward managers, and a programme around clear roles and responsibilities.

Manager told us that some staff on COVID-19 wards were really struggling and had planned sessions with ward managers and band six staff to identify any signs of post-traumatic stress disorder (PTSD).

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

The gastroenterology inflammatory bowel disease (IBD) service and the pharmacy team at the trust were being considered for an award in the 'Improving Safety in Medicines Management' category of this year's Health Service Journal (HSJ) Patient Safety Awards.

Managers we spoke with told us they had a number of developments in progress including ward accreditation, an audit database to help identify excellence and gaps. Joint training initiatives with mental health partners, additional training to support de-escalation for complex patients, psychological support for staff, including reflective sessions in practice.

The trust had implemented an upper gastrointestinal bleed out of hours advisory service.

Medical care (including older people's care)

The trust was looking to implement a new patient record management system.

The new frailty assessment service for patients who came through the urgent and emergency care department was in progress. The team were looking to implement a multidisciplinary team assessment within the service so people at risk of falls had a falls assessment before returning to community.

Urgent and emergency services

Inadequate 

Is the service safe?

Inadequate 

Our previous rating of inadequate remains.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff; however not all medical staff had completed it.

Paediatric staff displayed their compliance with annual mandatory training on their quality board. Compliance was 80% at July 2021, this did not meet the trust target of 90%.

Nursing staff received and kept up to date with their mandatory training. Data supplied by the trust showed nurse staff mandatory training compliance was 97%. This exceeded the trust target of 90%.

Medical staff received but were not up to date with their mandatory training. Data supplied by the trust showed medical staff compliance with mandatory training was 58% which did not meet the trust 90% target.

Managers monitored mandatory training. Staff discussed any mandatory training concerns as part of their monthly urgent and emergency care (U&EC) patient safety and quality (PS&Q) meetings. This was evidenced in meeting minutes dated 15 June and 20 July 2021.

The paediatric matron informed us that a nurse trained in emergency paediatric advanced life support (EPALS) was available on every shift this was in line with standard 13 of the standards for children in emergency care settings.

Safeguarding

Most staff had training on how to recognise and report abuse, however, they did not always apply it and did not always work with other agencies to do so.

Nursing staff received training specific for their role on how to recognise and report abuse and compliance with safeguarding level two and level three adults and children training exceeded the trust target.

Paediatric staff displayed their compliance with annual safeguarding level three training on their quality board. Compliance was 78% at July 2021, this did not meet the trust target of 90%.

Medical staff received training specific for their role on how to recognise and report abuse however, training compliance for safeguarding adults level three and safeguarding children level three was 53%. This did not meet trust target of 90%. The trust told us they had taken action to address the compliance issue; for example, allocating time for staff to complete the training and emailing non-compliant individuals to highlight their need to take action.

Staff knew how to identify adults and children at risk of, or suffering, significant harm but did not always work with other agencies to protect them. One patient who presented to the department was very vulnerable, staff had not raised a safeguarding referral on the patient until they were readmitted for a second time.

The most recent documentation audit data provided by the trust for the week commencing 26 July 2021 showed safeguarding concerns were escalated properly in 50% of cases.

Paediatric nursing staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff used a Child Protection Information Sharing System (CPIS). However, one member of paediatric staff we observed did not identify a potential safeguarding concern for a child presenting with multiple head injuries until we had escalated our concerns. Staff then took the appropriate action and generated a safeguarding referral.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff mostly, used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean overall.

In general, all areas were clean and had suitable furnishings which were clean and well-maintained. However, the mental health cubicle in the majors area was unclean with dirt and litter on the floor. We escalated our concerns and staff cleaned the room.

At our previous inspection (February 2021), we took action against the trust in the form of a section 29A Warning Notice and told them they must ensure all staff comply with all trust infection prevention and control (IPC) guidance in order to minimise the risk of the spread of infection. We were not assured the trust had sufficiently addressed this concern.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). We observed two registered nurses (RNs) transfer a patient from a trolley to a bed without wearing aprons and a catering staff member entered then left the room of a potential *C.difficile* patient and continued to provide refreshments without changing their PPE.

Infection prevention and control (IPC) champions undertook monthly PPE audits throughout the department. Data shared by the trust for the period January 2021 to July 2021 showed an improving trend ranging from 78% in January 2021 to 92% in July 2021 with March recording 98% compliance. This was close to trust target of 100%.

Staff were caring for a potential *C.difficile* patient in a side room in the majors department. Staff had not displayed any warning signs regarding the infection risk posed by the patient. We escalated this at the time and staff took appropriate action.

Hand washing stations and sanitisers were available throughout the ED. All staff wore scrubs and had bare arms below the elbow in line with trust policy. We observed staff regularly washed and sanitised their hands.

Infection prevention and control (IPC) champions undertook monthly hand hygiene audits throughout the department. Data shared by the trust for the period January 2021 to July 2021 showed an improving trend ranging from 75% compliance in February 2021 to 93% compliance in July 2021 with June recording 72% compliance. This did not meet trust target of 100%.

Paediatric staff displayed their compliance with hand hygiene audits on their quality board. Compliance was 100% in July 2021.

Paediatric staff displayed their compliance with cleaning audits on their quality board. Compliance was 100% in July 2021.

Staff discussed any IPC concerns as part of their monthly urgent and emergency care (U&EC) patient safety and quality (PS&Q) meetings. This was evidenced in meeting minutes dated 15 June and 20 July 2021.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff managed clinical waste well.

The emergency department (ED) comprised of several areas; reception, minors, majors, resus, rapid assessment and triage (RAT), clinical decision unit (CDU) and paediatric ED. The Respiratory Emergency Department (RED ED), for COVID symptomatic patients, was located in a separate area, co-located to the main Emergency Department. The area had a separate entrance for ambulance and walk in patients. Entrance to the department was by swipe card only.

The paediatric department was in a separate area of the ED and there was clear audio and visual separation of the children's waiting area from the adult section. Entrance to the paediatric department was by swipe card or buzzer with CCTV and exit was also by swipe card only. This ensured the safety of the children.

Paediatric ED had six cubicles and a high dependency room which was fully equipped for resuscitation of children.

In the adults ED, the minors area had one side room, four trolley cubicles and 11 seats. The majors area had 16 cubicles which included one mental health room, one aerosol generating procedures (AGP) room equipped for resuscitation and 4 side rooms. The CDU had five trolley cubicles, three reclining chairs and three seats, RAT had four cubicles and resus had four trolley cubicles each one equipped for resuscitation.

Two patient toilet cubicles in the majors area did not have emergency pull cords installed. We escalated this to staff who explained they had been removed to reduce ligature points for those patients presenting with mental ill health. However, there were still other ligature points present in the cubicle. After our inspection, the trust told us that all toilets have emergency buzzers.

The patient shower and toilet was out of order, staff told us they had been out of order for several weeks and was still awaiting repair.

Three out of four of the emergency alarms in the mental health room did not work. We escalated this during our inspection and the trust took action to repair them immediately.

Staff in the paediatric emergency department showed us the room used for children who presented with mental ill health. The room was not fit for purpose. It was out of line of sight of nurses, was full of equipment and did not have an emergency call alarm system. Staff told us they emptied it when required but some of the equipment was secured to the

wall. After our inspection, the trust shared the risk assessment they had completed for the room dated 17 August 2021, the risk assessment declared the room ligature free. We were not assured there was a comprehensive process in place to ensure the room was kept ligature free when in use or suitable for providing care of children presenting with a mental health crisis.

Patients could not always reach call bells and staff did not always respond quickly when called. One patient, who was secured to a spinal board and wearing a neck brace, was calling out verbally for pain relief as his nurse call bell was still in the holder on the wall. Staff responded only when we had alerted them.

Following our previous inspection (February 2021) where we identified the aerosol generating procedures (AGP) room was not fit for purpose, the trust had adapted a room to use for AGPs. AGPs are treatments where infectious material can become airborne and requires a higher level of personal protective equipment (PPE) for staff. The new AGP room was large enough to accommodate all the equipment and staff required during the procedure. However, the bin for disposal of contaminated PPE was inside the room. Two staff told us they removed their PPE in the room. This meant that staff were potentially exposed to airborne particles once they had taken off their PPE. Another member of staff told us that the bin was brought outside the room and doffing of PPE was carried out in the corridor immediately outside the room with the doors closed at either end. This was in line with trust policy. We were not assured staff were familiar with the policy and procedure for doffing PPE.

Staff carried out daily safety checks of specialist equipment across the adult ED. We reviewed the equipment checklist records for resuscitation equipment throughout the department. Staff had completed checks in line with trust policy. This was an improvement from our inspection in February 2021.

Paediatric staff displayed their compliance with daily resus equipment checks on their quality board. Compliance was 100% in July 2021.

The service had suitable facilities to meet the needs of patients' families. The service had a family room which was available for staff to use when breaking bad news. The room was clean and clutter free in line with trust IPC guidelines.

We observed staff disposed of clinical waste safely. Staff labelled sharps disposal correctly and not overfilled.

Assessing and responding to patient risk

Staff did not always complete risk assessments for each patient in a timely manner. They did not always remove or minimise risks to patients. Staff did not identify and quickly act upon patients at risk of deterioration.

There was no validated and audited system in place at the front door to the ED to identify critically ill patients, whether arriving by ambulance or walking and patients were not managed as directed by national guidelines.

At our previous inspection (February 2021) we took action against the trust in the form of a section 29A Warning Notice and told them they must ensure the triage process is robust and accurately identifies those patients who are the most sick. We were not assured the trust had sufficiently addressed this concern.

Urgent and emergency services

A registered nurse (RN) and a health care assistant (HCA) used patient symptoms and clinical observations to stream patients when they self-presented at ED. Staff could refer patients to opticians, GPs or an urgent treatment centre (UTC) or admit to the main ED. However, we found staff streamed patients on order of presentation rather than clinical priority. For example, we saw a patient present to reception with chest pain who waited 30 minutes for streaming. Another patient who presented with palpitations waited over 45 minutes for streaming.

Patients identified as requiring further treatment in the department were then directed to the rapid access and triage area (RAT) for further investigations. During the inspection, at 3.30pm, patients had to wait three hours and fifty-five minutes for RAT. We escalated this to the trust who took action and brought an additional triage team in to support. However, at 5pm, patients waited over four hours for triage.

Patients arriving at the hospital by ambulance generally unloaded directly into the RAT area. However, when the RAT area was full ambulance staff unloaded patients into a designated corridor space and provided care for them there. The hospital ambulance liaison officer (HALO) who was a staff member based at the trust but employed by the ambulance service, liaised with the nurse in charge and the ambulance crews regarding patients waiting for RAT.

We escalated two patients who were waiting in the corridor for RAT having been brought to ED by ambulance; one had attended after a fall and had an actively bleeding head injury and was on blood thinners and had not been to RAT after 45 minutes. The second patient was extremely vulnerable. They arrived in ED after being found collapsed and unresponsive, they were seen after 2hours and 26 mins after we had escalated to the consultant.

During rapid assessment and triage, an advanced nurse practitioner (ANP) completed initial observations using the national early warning scores (NEWS2), symptoms and professional judgement for all patients who were considered to need admission to ED. The trust did not use a nationally recognised triage tool, for example the Manchester triage tool, and had not audited the effectiveness of their process. This meant we could not be assured that the triage system was identifying the sickest patients first.

We reviewed the rapid assessment and treatment within the ED policy, version 1, issued November 2018. The policy did not have any references. This meant we were unable to identify what guidance the trust had based their triage procedure on.

Staff used the national early warning scores 2 (NEWS2), a nationally recognised tool, to identify deteriorating patients. However, the frequency of staff monitoring the patients was not in line with trust policy.

We reviewed nine patient paper records for timeliness of observations and cross checked these with electronic records on Nerve Centre on the hand held electronic device. Seven patients had not received timely observations with gaps of between three and five hours. This was not in line with prompts displayed on the nerve centre where observations should be recorded hourly.

We recorded one patient who had arrived in the department and did not have their observations completed until three hours later.

Data supplied by the trust showed NEWS2 compliance was 86% from January 2021 to July 2021. This meant approximately 14% of all patients presenting in the department did not receive their observations in line with trust

policy. Information provided by the trust after the inspection stated all walk-in patients had their observations taken by the streaming HCA. Patients arriving by ambulance had an additional set of observations completed during their RAT assessment. However, we were not assured that the timeliness of ongoing monitoring of patients in the ED was appropriate.

The most recent documentation audit data provided by the trust for the week commencing 26 July 2021 showed observations recorded within 15 minutes of arrival was 50%.

Data supplied by the trust showed that paediatric compliance with the completion of paediatric early warning scores (PEWS) was on average 92% from January 2021 to July 2021.

Staff used recognised tools to undertake risk assessments for patients presenting to the department. However, staff did not always complete risk assessments for each patient on admission.

At our previous inspection (February 2021) we took action against the trust in the form of a section 29A Warning Notice and told them they must ensure all appropriate risk assessments for patients attending the department are completed in a timely way to ensure appropriate mitigating actions can be taken. We were not assured the trust had sufficiently addressed this concern.

We reviewed 10 patient paper records for the appropriateness of risk assessments and cross referenced these with the electronic records held on Nerve centre. Staff had completed appropriate risk assessments in six of these 10 records, however, staff had not followed up on the outcome in three of the six therefore, only three had been completed and acted on appropriately.

Staff did not always deal with any specific risk issues. Two patients presented to the department and were identified as high risk of pressure ulcers. One patient did not receive any pressure care for eight hours, we escalated this at the time and the trust took action to provide the appropriate equipment. The other patient had waited for three hours.

The most recent documentation audit data provided by the trust for the week commencing 26 July 2021 showed Waterlow scores were completed and actioned in 27% of cases.

Another patient who was recorded as being high risk of falling and should be receiving 1:1 supervision was allowed to walk around the department unsupervised. Staff contacted the family of the patient and they attended to provide 1:1 supervision for the patient.

The most recent documentation audit data provided by the trust for the week commencing 26 July 2021 showed falls assessment completion was 70% and falls prevention plan completion was 55%.

We observed a patient who was secured to a spinal board with head blocks in place in line with national guidelines around the care of patients with suspected spinal injury. The patient was in a corridor and had been there approximately 15 minutes without supervision. This was potentially life threatening for the patient if they had vomited. We escalated our concerns and nursing staff moved the patient into majors area immediately. After the inspection we asked the trust for the policy for the care of patients in spinal blocks. The trust responded that they did not have this policy but would update the Trauma Patient Management in Emergency Department standard operating procedure (SOP) to ensure this includes the guidelines on spinal stabilisation.

Urgent and emergency services

The trust did not complete risk assessments for the appropriate use of bed rails. We saw one patient who was known to be living with dementia had climbed out of the trolley around the bed rails. We escalated another patient who had their leg trapped through the bed rails. Bed rails are not suitable in all situations as they can increase the risk of harm to patients.

It was not trust policy to complete risk assessments for venous thromboembolism (VTE) in the ED. This was done once the patient was admitted to a ward. However, some patients we observed had been in the ED over 12 hours, this meant that they were at increased risk of developing a VTE. This was not in line with National Institute for Health and Care Excellence (NICE) guidelines that all patients, on admission, receive an assessment of VTE and bleeding risk using the clinical risk assessment criteria described in the national tool.

At our previous inspection (February 2021) we took action against the trust in the form of a section 29A Warning Notice and told them they must ensure all risk assessments for patients presenting with a mental health crisis are completed in a timely way in order to identify and mitigate any risks to patient and staff safety. We were not assured the trust had sufficiently addressed this concern.

Staff had completed the mental health (MH) risk assessment for a patient who presented in the department in a mental ill health crisis. The outcome recorded the patient was high risk and needed 1:1 care. We saw the patient unsupervised on three separate occasions, for approximately five minutes on one occasion. This meant the patient had been able to enter the bay of another patient causing distress. We escalated this at the time and the trust asked a family member to support the patient.

The most recent documentation audit data provided by the trust for the week commencing 26 July 2021, showed mental health (MH) documentation safety plan completion and MH risk assessment completion was 70% and 67% respectively.

We listened to the nurse handover at the morning shift change in the majors area. The handover did not cover all individual patients in the area, not all patient plans were known and the handover did not include necessary key information to keep patients safe, for example which patients were at risk of falls.

Paediatric staff displayed their compliance with paediatric basic life support (BLS) training on their quality board. Compliance was 50% in July 2021, this did not meet the trust target of 90%.

Paediatric staff displayed their compliance with paediatric immediate life support (PILS) training on their quality board. Compliance was 78% in July 2021, this did not meet the trust target of 90%.

At our previous inspection in (February 2021), we issued the trust with a Section 29A warning notice as the trust had not taken action to mitigate the risks associated with the lack of an endoscopy service out of hours. At this inspection we found staff could articulate the process to be followed if a patient presented to the department with an upper gastrointestinal (GI) bleed out of hours.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). Staff knew how to make an urgent referral to them and received a timely response.

Staff arranged psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. We saw a nurse requesting a mental health review for a patient who had presented with a mental health crisis. The mental health team arrived within eight minutes.

Staff considered the possibility of patients presenting with sepsis as part of their "first hour assessment". We saw one patient who presented to the department with suspected sepsis. Staff commenced the sepsis tool in line with trust policy and administered antibiotics within one hour, in line with national guidance and recommended pathways.

Mortality and morbidity review meetings were not being undertaken at the time of inspection. The trust told us they recognised that for the last three months there had not been any formal mortality and morbidity (M&M) meetings, this has been primarily due to structure and leadership changes and operational pressures. Over the COVID-19 period the trust suspended M&M meetings and these were not recommenced until April 2021.

Minutes of the April M&M meeting recorded attendees, set out the terms of reference for the meeting, discussed the ED March death report and set the next date as May 2021.

Nurse staffing

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

There were not enough qualified registered nurses (RNs) to provide safe care and treatment in the adult emergency department (ED) and the number of nurses and healthcare assistants (HCA) did not match the planned numbers.

At our previous inspection (February 2021) we took action against the trust in the form of a section 29A Warning Notice and told them they must ensure that staffing resources are used efficiently throughout the ED to reduce delays to patients. We were not assured the trust had taken sufficient action to address this concern.

The trust used a safer staffing tool to identify the number and skill mix of staff required on all departments. On the day of our inspection, the ED was below planned staffing levels for registered nurses, and health care assistants. There were occasions where the inspection team could not locate any nurses in the ED majors to assist them with urgent patient safety issues. We were concerned that the reduced staffing levels were impacting on patient safety

Staff reviewed the number and grade of nurses, nursing assistants and healthcare assistants at team huddles throughout the day. Staff escalated to senior leaders when there were staffing shortages. We saw senior leaders move staff from other areas in the hospital to mitigate the staffing shortage.

The trust board papers (June 2021) showed staffing fill rates for registered nursing staff day shifts in March were 83% rising to 87% in April 2021 against a target of 95%. Fill rates for night shifts were greater than 95%.

Managers used bank and agency staff and requested staff familiar with the service. Data shared by the trust showed from May 2021 to June 2021, on average, 20% of registered nurse day shifts and 42% of night shifts were filled by bank or agency staff. The trust told us bank staff working in ED were substantive staff working additional shifts so were familiar with the department. The majority of agency staff were regular agency who worked a significant number of shifts per month in the department. In July, 45 shifts were filled with agency staff with one agency nurse undertaking 12 shifts and another 11 shifts. This means staff were familiar with systems and processes in the ED and were generally more able to care for patients safely.

There were enough paediatric nurses with the right skills and qualifications to care for children in the paediatric emergency department. However, the paediatric department had a vacancy rate of nine whole time equivalent nurses and employed long term agency staff to mitigate risks to patient safety.

Urgent and emergency services

The paediatric matron informed us that a nurse trained in emergency paediatric advanced life support (EPALS) was available on every shift this was in line with standard 13 of the standards for children in emergency care settings.

NHS Digital A&E quality indicators showed the sickness rate for the Urgent & Emergency care core services had been consistently lower at the trust than the overall and national sickness rates since March 2020.

Staff discussed staffing concerns at their monthly urgent and emergency care (U&EC) patient safety and quality meeting and this was recorded in the meeting minutes dated 18 May 2021 and June 2021.

Medical staffing

The service had enough medical staff with the right qualifications, skills and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, consultant cover was not in line with the Royal College of Emergency Medicine (RCEM) guidelines.

Consultant cover was not in line with Royal College of Emergency Medicine (RCEM) which recommend consultants provide 16 hours of cover as opposed to the 14 hours provided in the department.

The service was operating with ten consultants. A consultant told us the trust had accepted a business case to increase this number to 12. Seven of the consultants were on the General Medical Council (GMC) specialist register. The trust had four specialist paediatric emergency consultants.

The paediatric emergency department had enough medical staff to keep patients safe. Paediatric medical cover was provided by a paediatric registrar and a consultant paediatrician from Monday to Friday during daytime hours, with cover provided by a registrar and a senior house officer outside these times supported by an on call paediatric consultant.

The medical staff matched the planned number. This was one consultant providing care between 9am and 1pm and one consultant between 1pm and 5pm. The service always had a consultant on call during evenings and weekends, one consultant was on call from 5pm until 8am.

NHS digital workforce statistics showed in March 2021, the proportion of consultant staff reported to be working at the trust (20%) was lower than the England average (29%), with greater representation of middle-career staff and registrars.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Consultants were supported by a team of junior doctors. Middle grade doctors worked on overlapping shifts as did the foundation year doctors in the department.

Between 8am and 5pm there were three registrars and four senior house officers available. Between 1pm and 10pm, there were six senior house officers and two registrars. From 10pm until the following morning there were three senior house officers and three registrars.

Records

Staff did not always keep detailed and contemporaneous records of patients' care and treatment. Records were easily available to all staff providing care.

The trust used a combination of paper and electronic records in the ED. Patient paper notes were not comprehensive or contemporaneous. Staff began the completion of the booklet "My patient journey through the ED" once the patient was in rapid assessment and triage (RAT). Staff completed the speciality assessment tool once the patient had been referred to and seen by the speciality. Staff stored these nursing notes in open record trolleys at the nurse station so they were easily accessible to all staff.

Staff used an electronic device to access Nerve Centre where they could record any Waterlow and falls risk assessments all other risk assessments should be completed in the ED paper booklet.

We reviewed the nursing record of one patient who presented with a grade four pressure ulcer. There were no entries in the record relating to pressure care. Senior leaders told us after the inspection that nursing staff had updated his records retrospectively.

Staff discussed concerns around record keeping at their monthly urgent and emergency care (U&EC) PS&Q meeting dated 18 May 2021. Staff described problems with the poor level of completion of falls risk assessments and Waterlow risk assessment.

The director of nursing told us the trust were working towards an integrated digital records system.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. We observed two RNs preparing controlled drugs in line with trust policy.

Staff asked patients to state their name and date of birth and confirmed this with the patient's wrist band before giving any medicines.

Paediatric nursing staff used patient group directions to administer medicines for pain relief to children. This meant children could receive appropriate pain relief quickly without waiting for a prescription.

Incidents

Staff recognised and reported incidents appropriately. Managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. We observed a RN completing an incident report relating to a patient who had presented with a grade four pressure ulcer in line with trust policy.

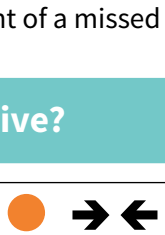
Staff understood the duty of candour. Two RNs we spoke with knew about the duty of candour and when the regulation would apply.

Staff discussed incidents and shared the learning at their monthly urgent and emergency (U&E) care PS&Q meeting. This was evidenced in meeting minutes dated 18 May and 15 June 2021.

Urgent and emergency services

There was evidence that changes had been made as a result of feedback. Urgent and emergency (U&E) care PS&Q meeting minutes dated 18 May 2021 evidenced there had been a change in policy and procedure as a direct result of learning from a patient incident of a missed fracture.

Is the service responsive?

Requires Improvement 

Our previous rating of requires improvement remains.

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the needs of the local population. There was adequate seating and space in reception and waiting areas which allowed for COVID-19 distancing precautions. People did not routinely have to stand while they were waiting to speak to reception.

At the time of inspection, due to COVID-19 the trust policy was patients only in the adult emergency department (ED) reception unless there was an additional need.

Staff displayed and updated a white board at the entrance to the ED reception to tell people what the current waiting times to be seen were.

Facilities and premises were not always appropriate for the services being delivered. For example, the paediatric mental health room was not fit for purpose, however, there were baby changing facilities in the paediatric emergency department.

Staff could access emergency adult mental health support 24 hours a day, seven days a week for patients with mental health problems. Staff in the paediatric department contacted child and adolescent mental health service (CAMHS) for advice and support when required.

Access and flow

People could access the service when they needed it but did not always receive the right care in a timely manner. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were worse than national standards.

Patients accessed the service by self-presentation at reception or via ambulance.

NHS Digital A&E quality indicators showed the total attendances at the trust had increased in line with national trends. In June 2021, the trust recorded the highest number of total attendances over the past two years. The seven day rolling total for total attendances at the trust increased to nearly 3,000 at the end of June.

Urgent and emergency services

Performance against the percentage of patients waiting over four hours from the decision to admit to admission was worse in June 2021. Senior hospital staff discussed bed occupancy, capacity and discharges as well as patients awaiting admission as part of their regular huddle meetings held throughout the day.

NHS Digital A&E quality indicators showed an increase in the number of ambulance handovers taking longer than 30 and 60 minutes. Throughout the day, at different times, we saw ambulance staff were caring for patients in the corridor while they waited for handover and rapid assessment and triage (RAT).

Managers monitored waiting times, but patients could not always access emergency services when needed and receive treatment within agreed timeframes and national targets. The trusts June 2021 board papers highlighted the impact of COVID-19 on performance against the four hour standard and ambulance handover.

The most recent NHS Digital A&E quality indicators for 2021 showed the trust continued to perform below the regional and national standard for four hour waits and shows a deteriorating trend; April 77%, May 74%, June 71% and 70% in July.

NHS Digital A&E quality indicators showed the median (average) time patients spent in the ED was 204 minutes and showed a worsening trend; April 2021, 188 minutes and May 2021, 199 minutes.

NHS Digital A&E quality indicators showed the percentage of ED attendances was in line with England. In both years, the trust had greater attendances resulting in admission than the England average.

NHS Digital A&E quality indicators showed the percentage of patients waiting over four hours from the decision to admit (DTA) to admission at the trust had been gradually decreasing (improving) since the peak of the second wave of the pandemic.

The trust had a clinical decision unit (CDU) to allow a short period of observation, investigation or treatment prior to discharge. The unit was nurse led. We did not see the CDU covered in the medical staff handover. Responsibility and oversight of patients in CDU was the responsibility of the consultant in charge.

At our previous inspection (February 2021) we took action against the trust in the form of a requirement notice and told them they must ensure that there is robust oversight of the clinical decisions unit (CDU) including that patients cared for there meet the inclusion criteria. We were not assured the trust had taken sufficient action to address this concern.

Managers did not always monitor that patient movements between wards were appropriate. Staff told us that patients who had decisions to admit (DTA) to a ward were often transferred to wait in the clinical decisions unit (CDU) despite this being in the trust CDU exclusion criteria. We observed one patient who had a DTA had been in CDU over 24 hours. We escalated this patient and they were moved to a ward immediately. The trust CDU policy has a clear exclusion and inclusion criteria, however, it also allows a clinician to use their judgement and admit a patient who would otherwise be excluded due to capacity and demand, for example. However, this was not clear to staff or clear in patient records.

Information was available to staff on the status of patients and on the performance of the department through the electronic display screen in the ED. The inspection team requested information relating to patient numbers throughout the day and staff were able to make use of the system to quickly report on the situation at any time.

Urgent and emergency care (U&EC) board meeting minutes dated 20 May and 17 June 2021 evidenced managers reviewed the performance of the department on a monthly basis.

Urgent and emergency services

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff discussed complaints and shared the learning at their monthly urgent and emergency (U&E) care PS&Q meeting. This was evidenced in meeting minutes dated 18 May and 15 June 2021.

Is the service well-led?

Inadequate 

Our previous rating of inadequate remains.

Leadership

Service leaders had the skills and abilities to run the service. However, recent changes to leadership within the service were yet to be fully embedded. Service leaders did not manage the priorities and issues the service faced. They were not always visible and approachable in the service for patients and staff.

Following on from our previous inspection in February 2021, the trust had re-configured the health care groups (HCG). Urgent and emergency care (U&EC) was now formed as a single HCG having previously been together with medicine. Senior leaders told us that this would allow them to focus on urgent and emergency care and strengthen the leadership of the service.

Urgent and emergency care HCG was led by an associate medical director (AMD), general manager, operational director and associate director of nursing. The emergency department (ED) was led by a team of managers including the clinical lead for ED, the nursing lead for ED and the operations lead for ED. Our interviews with the senior leadership team demonstrated that leaders were aware of the priorities and challenges the service faced; however, they were still in the process of identifying appropriate actions to address current and future challenges, including those identified at this recent inspection.

During the inspection, the associate director of operations, the service manager and the chief operating officer (COO) were very visible and supportive of staff in the ED. Staff told us that this was not always the case and usually only the COO provided support and was proactive.

Culture

Staff felt respected, supported and valued by each other. The service provided opportunities for career development. The service had an open culture where staff could raise concerns without fear.

All the staff we spoke with told us how proud they were of each other and of the service they provided. This was despite the challenges and demands on the service during the national pandemic.

Urgent and emergency services

Staff of all grades and teams interacted with each other respectfully and professionally. Staff we spoke with described the resilience of their peers and colleagues.

Notices displayed in the seminar room invited staff to attend for development and leadership courses.

Notices displayed in the seminar room invited staff to attend free wellbeing workshops and courses to support their mental and physical wellbeing.

Two staff we spoke with were aware of the freedom to speak up guardian.

Governance

Leaders operated governance processes, throughout the service and with partner organisations; however, we could not be assured they were always effective. Staff had regular opportunities to meet, discuss and learn from the performance of the service.

There were still not effective systems, structures and processes to support the delivery of the strategy and quality patient care. At the time of our inspection, the trust was already in the process of reviewing their governance structure and processes. Service leaders we spoke with acknowledged that whilst some improvements to governance had been made since our previous inspection in February 2021, there was further work to do. This had been identified prior to this inspection through internal and external governance review processes in June 2021 and the outcome of this inspection confirmed this. There was a plan in place to strengthen governance at all levels of the organisation. For urgent and emergency care this included formalising roles and responsibilities for all staff and the introduction of internal professional performance standards; however, this was yet to be fully implemented and embedded. This was apparent from the continued lack of clarity around areas such as the clinical decisions unit and lack of effective triage process.

Whilst all of levels of governance and management still did not function effectively, U&EC service leaders had made some improvements in governance meetings attendance. ED governance meetings reported into a number of governance and committee sub-groups including patient safety and performance and finance meetings. The sub-groups reported to trust board committees such as the quality and safety committee which then reported to the trust board. The following are examples of ED governance meetings:

U&E care board meeting was held monthly. Minutes of meetings dated 20 May and 17 June 2021 recorded good attendance from service leaders. This was an improvement on our previous inspection (February 2021).

U&E care patient safety and quality meetings were held monthly. Minutes of meetings dated 18 May and 15 June 2021 recorded good attendance from service leaders. This was an improvement on our previous inspection (February 2021).

Mortality and morbidity meetings had not been held from January to March 2021. The trust had reintroduced them starting from April 2021.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. They identified and escalated relevant risks and issues but did not always identify actions to reduce their impact quickly.

There was insufficient oversight of the quality of records and the managers had failed to address the issue, this was brought to the trust's attention at our previous comprehensive inspection in 2019 and our focused inspection in February 2021.

The trust was not able to provide assurances of the effectiveness of the triage tool they used and there was a lack of audit of the process despite this being brought to the trust's attention in February 2021 when there was a higher than regional number of re attendance in ED within seven days. After our inspection, the trust informed of us plans they have to strengthen the triage process. This includes trialling a new triage model in September 2021 comprising of a multi-disciplinary team with the aim of making the ambulance handover and triage more effective.

The use of escalation areas and the clinical decisions unit was not operating in line with the trust's operational policy. On occasions, the ED utilised the clinical decision unit as an escalation area. This meant patients stayed there for longer than allowed by the service operational protocol. During our inspection we observed one patient in the CDU for longer than 24 hours. This is not in line with trust policy.

The trust had a policy called Emergency Department Escalation plan v1. October 2020. The policy detailed what steps staff should take if the department reached capacity. These steps were designed to ease pressures and improve access and flow within the department and throughout the hospital. We observed staff escalating concerns around capacity.

Urgent and emergency care (U&EC) board meeting minutes dated 20 May and 17 June 2021 evidenced managers reviewed the risks of the department on a monthly basis.

We reviewed the trust ED risk register. All the risks we identified had already been identified and been recorded by the trust. For example, nurse staffing, risk assessments and no ligature free toilets for patients presenting with mental health crisis. Risks had been assigned to senior leaders and there was clear evidence of review and update of mitigations. However, the lack of ligature free toilet facilities in the ED had been identified as a risk 9 April 2021 and rated as amber, and still remained 10 August 2021. Mitigating actions did not protect patients from potential harm.

Maternity

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

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

Mandatory training

The service provided mandatory training in key skills to all staff. Not all staff completed it; however, managers had plans in place to ensure improvements.

The mandatory training was comprehensive and met the needs of women and staff. Managers monitored mandatory training and alerted staff when they needed to update their training. Staff attendance at training was monitored electronically by managers, and staff received reminders to complete training to ensure compliance.

We were told that midwifery staff compliance against mandatory training had been affected by the pandemic. Overall compliance with the top core mandatory training subjects was 88% which didn't meet the 90% target. Staff were compliant with adults and paediatric basic life support achieving 92% against a 90% target and were 90% compliant with moving and handling training. Staff fell short of meeting the target for compliance for infection prevention control which was at 83%. This demonstrated a variable picture of overall compliance.

Staff received mandatory cardiotocography (CTG) training which measures a baby's heart rate and monitors the contractions in the womb (uterus). CTG is used both before birth (antenatally) and during labour, to monitor the baby for any signs of distress. CTG training compliance as at July 2021 showed 78% of midwives had completed the training with a trajectory to achieve 100% by October 2021 as CTG training sessions were scheduled monthly.

Maternity staff had an agreed alternative pathway to the Growth Assessment Protocol (GAP) with associated training. The pathway conformed to all aspects of the Saving Babies' Lives Version 2 care bundle. We were provided with detail relating to the alternative training (Symphysis Fundal Height Competency). 86% of midwives had completed the training against a target of 90%. This meant there remained some midwives awaiting training to help strengthen their skills.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, completion of safeguarding training for midwifery staff was below the trust's compliance target.

Midwifery and medical staff received mandatory safeguarding adults and children training up to level 3. Data provided by the trust showed mandatory safeguarding level 3 training was 72% for midwives and 68% for medical staff against a 95% target in July 2021. Managers told us that compliance with statutory and mandatory training for all maternity staff had been affected by the pandemic.

Managers monitored training compliance and the safeguarding team discussed monthly compliance figures at the patient, safety and quality meetings, in addition, managers received a report from the training team. However, staff were not always compliant with their training within agreed timescales which meant their skills were not updated in a timely way.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Women's records showed safeguarding questions were raised at assessment stage. Women's records showed the national enquiry question about domestic abuse was asked antenatally. Staff asked mental health questions in a sensitive way at assessment.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The trust had safeguarding leads with established links with maternity staff and external organisations to help keep people safe.

Staff followed safe procedures for children visiting the ward. At the time of inspection, there was limited visiting on the wards and no children visiting as a result of the pandemic. This was to be reviewed and restrictions revisited following national guidance and updates.

Staff followed the baby abduction policy and undertook baby abduction drills. Staff knew and understood how to respond to potential baby abduction. Staff had access to a baby abduction policy. Staff had a recent unannounced baby abduction skills and drills session and baby abduction was included in their mandatory training programme. This meant staff knew and understood how to respond to a baby abduction.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always use equipment and control measures to protect women, themselves and others from infection. They did not always keep equipment and the premises visibly clean.

Ward areas were not visibly clean with suitable furnishings which were well-maintained. For example, the cardiotocography (CTG) machines on one ward were dusty and we saw that the resuscitaire on the labour ward was also dusty. We saw that the walls on the wards had chipped paint and chairs in clinical areas were cracked with exposed foam.

Privacy curtains were not always clean or changed at regular intervals to reduce the risk of infection. Privacy curtains can become contaminated with microorganisms, which can then be transmitted to staff hands. We saw some curtains were dirty and had not been replaced in over six months; this meant they could be an infection risk. We escalated this to the matron to ensure the areas were cleaned and where appropriate curtains replaced.

Staff did not always demonstrate infection control principles were being consistently used. We requested infection control audits data, from January 2021 to June 2021 for surgical site infection, personal and protective equipment, handwashing, MRSA and C-Diff. The feedback from the trust was that they did gather trust wide MRSA and C-Diff data but did not audit it in maternity. The data provided by the trust had gaps in auditing hand hygiene for January, March, April and June, however over the course of the six months, overall compliance with hand hygiene was generally good, with only four occasions where they sat just below 100%.

Environment and equipment

Maternity

Staff did not always manage clinical waste well and checks of specialist emergency equipment were not consistent. The design, maintenance and layout of the premises may not always keep people safe.

The maternity wards were poorly signposted which made them difficult to locate. The postnatal ward was adjacent to the labour ward and there was no separate internal secure access between wards, however there was a secure external door. The maternity service ensured secure access only onto the areas with double airlock secure access systems. In addition, the birth centre had a separate entrance which was secure. This meant unauthorised people were unable to enter the rest of the maternity unit unless they had swipe card access.

There were no privacy curtains in the delivery rooms, this meant when the door was open you could see inside, and women's dignity might be compromised. There were no 'do not enter' or 'engaged' notices on the doors, making it difficult to know if a room was occupied or not. We escalated these concerns to highlight the need to ensure women's dignity.

During our inspection, theatre staff did not have leads to use the electrocardiography (ECG) machine during an emergency c-section. This meant that physicians did not have the ECG machine to monitor the vital signs of the heart for the woman and could have had an impact on the safety and wellbeing of that woman.

Staff did not always respond appropriately when specialist equipment required safety checks. We checked the adult resuscitation trolley which was locked and sealed, however we noted that it was not always checked on a daily basis; for example, we found five daily checks missing in May and one daily check missing in June. We also looked at the Cardiotocography (CTG) monitor daily checklist and noted four daily checks were missed in May, five in June and one in July. This meant there were inconsistent checks to ensure all equipment was always safe to use.

Not all electrical appliances had in date electrical testing completed, for example, out of all the equipment checked one CTG machine was due testing in December 2020, and this had not been completed. This might mean the equipment's efficacy was compromised. However, the trust provided us with documentation that demonstrated overall compliance with electrical safety tests in maternity equipment in July was 99%.

Staff did not manage clinical waste safely. We saw the dirty utility room was left unlocked and the door left open. The room was cluttered and untidy. Clean linen trolleys were among the dirty linen baskets and containers. There were storage boxes on the floor. All of which could be an infection control risk.

Arrangements for the control of substances hazardous to health (COSHH) were not always adhered to. Cleaning equipment should be stored securely in locked cupboards; however, we saw unsecured disinfectants in unlocked cupboards. This meant unauthorised persons could access hazardous cleaning materials.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each woman and take action to remove or minimise risks. Staff did not have access to robust systems to identify and quickly act upon women at risk of deterioration.

Staff did not have an embedded standardised triage system for maternity. Managers told us they had been working on a triage process and had introduced a new telephone triage tool on 21June 2021. Plans were in place to facilitate a dedicated space to enable face to face triage; however, this required estate reconfiguration. Medical cover was in place

to support the midwifery team with triaging those women identified with risks. Band six midwives on the labour ward were responsible for telephone triage. However, there was no associated guidance in place, midwives did not receive training and it was an added responsibility to a busy service. This meant that the system may not be robust enough to ensure the safety of women who used the service.

Staff did not always use a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. Staff completed, scored and escalated correctly seven of the ten 'Modified Early Obstetric Warning Score' (MEOWS) charts we reviewed. Three of the ten women did not have a recorded MEOWS score. Midwives used the charts to allow early recognition of physical deterioration in women by monitoring their vital signs. This meant we could not be assured that all women's observations were appropriately completed to keep them safe.

Staff knew about and dealt with most specific risk issues. We looked at ten women's records and saw most were fully completed with appropriate risk detail. For example, women had venous thromboembolism (VTE) assessments, in line with the service guidelines. VTE is a life threatening condition where a blood clot forms in a vein.

Women did not always have 'fresh eyes' if Cardiotocography (CTG) was performed to ensure they were working in line with national recommendations (NHS England, Saving Babies' Lives Version Two: A care bundle for reducing perinatal mortality (March 2019)). 'Fresh eyes' meant a second midwife, would review the CTG to ensure it was correctly interpreted and escalated if appropriate. Of the CTG documentation we looked at, four were not in line with National Institute for Health and Care Excellence (NICE) guidance, for example, staff did not consistently sign and date the CTG. This meant we could not be assured that observations took place to keep women and their babies safe.

Women were provided with reduced fetal movement leaflets in line with the Royal College of Obstetricians and Gynaecologists national guidance. The information leaflet helped women understand their baby's movements in pregnancy and prompted women on when to contact their healthcare provider.

Staff were issued with World Health Organisation (WHO) five steps to safer surgery checklists. The checklist was a tool that helped staff avoid errors during surgery. We observed an emergency c-section where we did not see staff use the WHO checklist. We escalated this concern to leaders and were assured that the checklist would be used in future. Staff carried out monthly WHO checklist audits. The results of the audits for May, June and July were 100%.

Shift changes and handovers were not formally recorded using recognised tools to document key information to keep women and babies safe. We observed labour ward midwifery handovers. They were brief and staff did not consistently use a recognised tool to facilitate and record the discussion. However, staff demonstrated good interactions, including sharing of safety detail, training and key messages including security messages which were written up on the board.

Multidisciplinary safety huddles did not take place. Safety huddles should include all key personnel involved in the woman and baby's care. However, our observations during inspection demonstrated that this did not always happen. For example, there were no anaesthetists present at the handovers we observed. We escalated this as a risk to the senior leadership team and they rectified this by introducing safety huddles that reflected best practice. All staff were emailed on the unit with the documentation and then leadership staff discussed the safety huddles during one to one discussions for assurances that the system was understood and would be embedded with immediate effect. This meant that women's safety concerns would be discussed regularly with the right people at regular periods throughout the day to keep them safe. Following our inspection, the trust provided evidence that demonstrated there was now a structured process for MDT safety huddles in place.

Midwifery staffing

Maternity

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

The service did not have enough midwifery staff to help keep women and babies safe. We looked at planned v actual rotas from January 2021 to June 2021 which demonstrated that there were not enough staff. However, managers calculated and reviewed the number and grade of midwives, maternity support workers and healthcare assistants needed for each shift in accordance with national guidance. Midwifery staffing was reviewed daily at least a week in advance. Midwives were deployed to all areas of maternity depending on the acuity of specific areas. The Birth Rate Plus acuity tool was introduced in March 2021 to aid the redeployment of staff to areas of higher acuity, this was reviewed every four hours.

Average vacancy rate for midwives between July 2020 to October 2021 was 2.42 full time equivalent. In January, the planned v actual rota demonstrated the service was short staffed on 23 out of the 30 days. In February, March, April, May and June the planned v actual data showed the service was understaffed on every day of those months. We looked at the risk register which described how acuity and reduced staffing levels increased safety concerns. For example, the incidence of delays of induction of labour.

We looked at incident reporting between July 2020 and July 2021. We looked at 36 recorded incidents that indicated delays for women during this period. All of which were a result of staffing, acuity and bed shortages. For example, three women with reduced fetal movements had delayed access to labour ward due to acuity.

The ward manager could adjust staffing levels daily according to the needs of women. When actual staff numbers fell below planned staff numbers the staffing co-ordinator, with a matron, ensured that bank shifts were released and if not filled, were escalated to agencies. The rotas were reviewed, and staff were requested to change shifts to cover gaps in the rota. Five community teams provide continuity of carer and 24-hour cover for the labour ward and birthing unit on an on-call basis. These midwives were used for escalation if required. In addition, three community midwives were on call every night for homebirths and escalation if required.

Midwives were sometimes tasked with additional responsibilities that reduced their time supporting women and babies. For example, the community midwifery team staff were responsible for covering a helpline (from 08.00 – 16.00). However, labour suite staff covered the helpline when community midwifery staff were unavailable. Midwives also covered triage over the telephone and labouring women. Staff told us they consistently had to escalate concerns to managers due to staffing concerns. This meant midwives had many areas of responsibility that would take them away from the job of looking after women and babies. There was no ward clerk cover on the day of inspection, and a ward clerk was only employed to work during the day, this meant midwifery staff were undertaking ward clerk duties which took them away from their core role of caring for women and babies.

Reduced staffing impacted negatively on those staff covering the maternity ward. Staff told us that around 50 percent of their time was spent going to escalation; particularly at night calling midwives in from home. Staff told us they were not getting breaks, that they were exhausted to the point of tears while on duty and that they did not feel they were being listened to by senior staff. We looked at staffing levels on the day of inspection and saw that the previous night 12 staff were expected for four clinical areas, however there were only 10 actual staff available and escalation processes were used to call in two midwives overnight. The ward were expecting 12 staff for day shift and there were 12 staff on duty, this meant staffing levels were met for day shift to help care for women on the labour ward.

Managers told us that specialist midwives assisted clinically if acuity was high. A band seven and band eight specialist midwife were on call every night. They also provided 24-hour cover at the weekend and could attend the unit to care if required. All specialist midwives we spoke to told us that they worked clinically regularly to support staffing shortages. This meant less time was spent completing the tasks to support the service. Specialist midwives had additional responsibilities such as governance and audits to complete which may have to be left in these circumstances.

Women in labour received one-to-one care to help ensure a good experience of care and reduce the likelihood of problems for the woman and her baby. During times of increased acuity, staff were redeployed from other areas to facilitate patient safety. We requested audits on NICE Clinical Guideline 190 (1-1 care in labour). The data provided by the trust demonstrated 100% compliance which had been consistently maintained. A specialist midwife had oversight of this via the birth register. This meant consistent one to one care was in line with NICE guidance, however, did mean reduced staffing levels across other areas.

The leadership team acknowledged the impact of reducing staffing and put in place mechanisms of support. They told us that midwifery staff reported being burnt out, fatigued, and sometimes working without safe staff numbers as a result of the pandemic. Leaders told us that to help staff recover

and rebuild resilience, they had implemented a focused health and wellbeing programme. This

included a 12 week Back to Better campaign to support staff with time to rest, reflect and recover.

Leaders told us that the health and well-being of staff continued to be a priority.

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, however, locum staff did not always have a full induction.

The service did not have enough medical staff to keep women and babies safe.

Obstetric staffing in antenatal clinics was identified as a risk on the risk register. This meant there was not always a consultant and registrar for every clinic to provide timely scans and scan reviews for women who attended for an ultrasound. In addition, staffing was identified on the risk register as a concern for delays in admissions to the antenatal ward and subsequent transfers to the delivery suite. The trust had identified control measures to reduce the risks; for example, a working group had been set up to monitor delays, an acuity application was used to monitor red flags and delays all of which were used to help keep women safe.

A need for more medical staff was highlighted in the Ockenden review and external reviews. A business case was accepted in April 2021 for two further consultants and five registrars. Managers expected full establishment by the end of October 2021. This meant there were plans to increase medical staffing to reach full establishment. Leaders provided us with evidence that demonstrated sustainability of the medical rota had improved with the appointment of a new cohort of trainees and recent registrar appointments.

Managers did not always make sure locums had a full induction to the service before they started work. The need to strengthen locum induction processes was identified in September/October 2020. The induction pack was further strengthened in January 2021. Managers were reviewing the locum induction following the two recent serious incidents and working across the Local Maternity and Neonatal Service Network (LMNS) to ensure they followed best practice. However, medical staff we spoke with told us that locums did not always have a full or effective induction.

The medical staffing did not match the planned number. Managers increased the number of registrars on the rotas in response to the Ockenden report. When possible, two registrars were planned on Saturday and Sunday and two registrars overnight on Friday, Saturday and Sunday. This was provided via additional locum shifts while awaiting start dates for recruited registrars. Managers and medical staff told us that locum usage had increased since April 2021. We were told staffing the middle grade rota was of concern, and that locums did not always arrive for their shifts.

Medical staffing sickness and absence was reported and escalated appropriately. If absences affected the rota, amendments were made to provide safe cover. Bank and agency were approached if necessary and the rotas were monitored on a daily basis. Registrars also covered planned activities and supported elective c-sections.

Medical staff told us they did not always feel supported and felt exhausted due to staffing issues which impacted on sickness levels.

Records

Staff did not always keep detailed records of women's care and treatment. Records were not always up-to-date or easily available to all staff providing care.

Women's notes were not always comprehensive. Three of the ten records we looked at did not have scores on charts that allowed early recognition of physical deterioration in women by monitoring their vital signs. Staff did not consistently sign and date cardiotocography results in line with national guidance.

Staff could access electronic records easily and securely using unique usernames and passwords. Handwritten notes were stored securely. However, there were three different systems in place to record and store maternal notes. This meant access to all up to date information would not be easily accessible to all staff providing care.

Medicines

The service used systems and processes to safely prescribe, administer and, record medicines. However, we found that medicines were not always stored correctly.

Medicines that required refrigeration were stored appropriately and fridge temperatures were checked. However, we were concerned that for 30 consecutive days, fridge temperature were out of the recommended range. This was escalated and pharmacy staff reviewed the medications efficacy which was not thought to have been affected. We were assured that this would be rectified, and staff would escalate if the fridge temperature remained high for an extended period to avoid adversely affecting medicines.

Staff followed systems and processes when safely prescribing, administering and recording medicines. However, medicines were not always stored appropriately to ensure access was limited to those authorised to access it. We saw a local anaesthetic was left on a delivery trolley in an area that was accessible to anyone on the ward.

Controlled drugs (medicines subject to additional security measures) were stored correctly in locked cupboards and stock was checked by two qualified members of staff twice a day.

Incidents

The service did not always manage safety incidents well. We were not assured that incidents were always graded correctly according to level of harm. Managers investigated incidents, however, did not always share lessons learned with the whole team and the wider service. Staff recognised and reported incidents and near misses. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. We saw incident details recorded and shared for learning purposes.

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff recorded and discussed incidents in meetings. We had discussions with staff about incidents, learning and improvement where they demonstrated an understanding of incidents and how to improve women's safety.

Staff reported serious incidents, however, we were not assured that incidents were correctly graded which could mean that opportunities for learning and improving patient safety could be missed. Staff reported ten serious incidents to the national reporting and learning system relating to maternity from June 2020 to June 2021. We reviewed 43 incidents recorded for March and April for obstetrics via the national reporting and learning system. There were six PPH incidents graded as low harm where massive haemorrhaging was indicated. The incident reporting system did not record a narrative to rationalise the grading. The trust had now introduced a new audit proforma with processes adopted for reviewing massive obstetric haemorrhage since July 2021. The proforma included standardising categorisation of harm. This was yet to be embedded.

We were not assured that there were effective systems in place to ensure learning was consistently shared amongst teams. Staff told us there was a serious incident summary produced on an email by the governance team. We saw that the antenatal team printed the summary off and some of the staff signed it up until May 2021, beyond that date there were no further entries. Other clinical areas did not print off the summary, this meant methods to review the learning varied and we were not assured all staff reviewed the information from incidents. Staff told us learning from serious incidents were sent every Monday and messages from incidents were shared with midwives. However, doctors told us that they did not receive detailed learning from incidents. There was a governance notice board in the staff area that listed incidents, trends and training.

Managers debriefed staff after serious incidents, however staff did not always feel they received the right support. Staff we spoke with told us that there was a bereavement midwife, however they were not always available. The leadership team told us they were working with the local mental health provider to offer psychological support across the maternity service.

The trust participated in the 2019 CQC Maternity Services Survey and scored 'about the same' as other providers for all questions including the three questions relating specifically to safety concerns. The trust was not an outlier in the 2019 survey and did not flag as 'worse' or 'much worse' in either of the 2017 and 2018 surveys.

Maternity

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation when things went wrong. Women's records included examples and we saw evidence in incident related documentation we reviewed. Staff provided us with examples of when they would use duty of candour and described the underpinning principles.

Safety Thermometer

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

The safety thermometer data collection portal was closed in April 2020 and alternative sources captured and reported on perineal trauma data, caesarean section rates, post-partum haemorrhage and separation from baby. Feedback from women on care received was captured via a QR code, friends and family, maternity voices partnership and the Patient Advice and Liaison Service. The trust's maternity dashboard also displayed all of these metrics and compliance. Staff told us and showed us the electronic tablet used to capture and review the data across wards and over different periods.

Is the service effective?

Requires Improvement 

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

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Information about the outcomes of women's care and treatment were routinely collected and monitored. The trust had a maternity dashboard in place, based on Royal College of Obstetricians and Gynaecology guidance. We reviewed the maternity dashboard dated April 2021 to June 2021. The dashboard was RAG rated with targets set for cardiotocography (CTG) training compliance, mode of delivery and maternal and neonatal morbidity and mortality. We saw targets were consistently not met across each of these areas. For example, the target for CTG training compliance was set at 80% for midwives and they achieved at best 73%.

Doctors and midwives told us they did not routinely have access to the maternity dashboard. Two consultants had seen the maternity dashboard, however they said this would not be normal. This meant the learning from the dashboard was not shared as standard or in line with national or local guidance to improve safety practice.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The trust provided us with the services' audit schedule for 2021/2022 which demonstrated a schedule of planned local audits over a twelve-month period. A team was assigned to carry out the audits.

Maternity

Maternity services had been the focus of national scrutiny following the publication of the Ockenden report. Leaders had responded to the requirements of the report and were actively working to improve services for women and their families. On reviewing the services response to the Ockenden report which was submitted on 10 February 2021, there were no unaddressed immediate and essential actions to be taken. All seven actions had been achieved and they had identified how they would mitigate any short-term risks. This meant there were no unaddressed requirements.

The trust was part of the Local Maternity and Neonatal Service Network (LMNS) with acute trusts in Hertfordshire. Best practice and learning from clinical incidents were shared across the LMNS. The trust had invited peer review of some maternity incidents to ensure that an external view was part of the investigation, this demonstrated a transparent approach to learning and improvement. The peer review identified a significant amount of good practice and made recommendations for changes which were being taken forward by the teams.

The trust engaged in national programmes to improve delivery of maternity services. The trust provided us with information in response to The Clinical Negligence Scheme for Trusts (CNST). This was an incentive scheme that outlined ten essential actions designed to improve the delivery of best practice in maternity and neonatal services. The trust provided us with information relating to safety actions. For example, safety action one related to the use of the National Perinatal Mortality Review Tool to review perinatal deaths. The report provided information on all deaths of babies at the trust in January, February, and March 2021 and the review process, findings and action plans arising from the reviews. Progress reports were submitted quarterly from December 2019. We saw documented case reviews in minutes from monthly meetings. This meant there was a system to provide assurance to the quality and safety committee that the family and women's services health group were meeting the standards required from Safety Action One of the Maternity Incentive scheme.

We discussed standards set out in CNST relating to transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme. We were told the trust had declared non-compliance for this standard, however there were plans for the new hospital. There was a guideline in place for transitional care and the last audit for compliance took place in December 2019.

The Maternity Safety Highlight Report dated 1 July 2020 to 30 September 2020 demonstrated that five of the 10 metrics for safety remained 'at risk'. Staffing and safety champions were two of the metrics indicated as continued risks. During our inspection we found continued concerns relating to medical and midwifery staffing. The safety champions had not been fully embedded or their role understood by all staff, however there were plans in place to help improve this.

The trust participated in the National Neonatal Audit Programme 2020 (based on data from 2019). The trust was within the expected range, or better than expected for all six metrics in the audit that applied to individual hospitals. This was also the case for the 2018 audit (based on 2017 data). We saw this documented in data and minutes from quality and safety committee meetings that took place quarterly.

The trust participated in the MBRRACE perinatal mortality surveillance report which was published in December 2020 (based on births in 2018). MBRRACE is a national collaborative programme of work involving the surveillance and investigation of maternal deaths, stillbirths and infant deaths. The MBRRACE report 2020 for the trust showed perinatal deaths within the expected range based on the numbers of perinatal deaths in 2018 and 2019. In July 2021, the trust reported an increase of 12 cases perinatal deaths which was above the 8.5 expected deaths. The Women's Service 2020/30 Strategy referenced MBRRACE and plans to continually improve outcomes, for example, there were plans to employ a risk management consultant.

Competent staff

Maternity

The service did not always make sure staff were competent for their roles. Managers did not always provide a timely appraisal of staff's work performance or regular supervision meetings with them to provide support and development.

Staff were experienced and qualified however, were not always up to date with their training to help strengthen their skills. Staff were monitored using a system to prompt training, learning and development and ensure competencies. We saw documented audits for compliance and competency which also identified where the gaps were. Staff carried out regular skills and drills exercises where they were observed and learned from practical exercises.

Practice development midwives (PDMs) organised mandatory training, inductions for new midwifery staff and band five midwives' (junior midwives) preceptorship training. A preceptorship is a period of time to guide and support all newly qualified practitioners to make the transition from student and to develop their practice further. The PDMs also facilitated skills and drills, learning from incidents and additional training when identified following audits. Midwives, including students, told us they received good opportunities for growth and felt supported by the PDM's. This meant there was a focus on support for staff competency and ensuring staff were effective in their roles to keep people safe.

Managers did not always give all new staff a full induction tailored to their role before they started work. Doctors told us there was no structured induction and we saw this referenced as a reason for incidents that impacted on the safety of women while using the service. We raised this an immediate concern with the leadership team and were provided with assurances that medical staff who were due to work that weekend were fully inducted and familiar with the service. We were assured that medical staff inductions would be prioritised for future shifts at the service.

Managers supported staff to develop through yearly, constructive appraisals of their work. The appraisal rate had been affected by the pandemic, however from May 2021 there was a demonstrable improvement. Leaders provided us with appraisal compliance rates from July 2020 to June 2021 for all staff and we saw that the maternity division remained non-compliant with completion rates averaging around 80%. This meant not all maternity staff had received an up to date appraisal. We looked at medical appraisal compliance rates from the same period and saw that there was one appraisal outstanding, this appraisal had an agreed extension. Medical revalidation was all within date. We looked at midwifery revalidation and saw that of 171 staff due there were 14 outstanding.

Consultants told us they did not have one to one job planning. We reviewed the risk register for the service, of which job planning was a recorded risk, and saw that in October 2020 a job plan review commenced, however it remained a concern up until July 2021. Managers told us that job planning was a significant focus and part of the trusts' 2021/22 aims for all care groups. To facilitate this, a planned away day was scheduled in June 2021 to review job plans with consultants.

Staff were trained to deliver the Practical Obstetric Multi-Professional Training (PROMPT) approach to obstetric emergency training and we saw a PROMPT training booklet which included sepsis training. Compliance rates were good across all staff disciplines. Midwives achieved 90%, maternity care assistants 93%, maternity nurses 100% and nursery nurses 100%. This meant that most staff on the wards were trained to help strengthen their skills.

Multidisciplinary working

Doctors, midwives and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care. However, multidisciplinary meetings were inconsistent and not always formally structured.

Maternity

Staff held regular multidisciplinary meetings to discuss women and improve their care, however they were not always formally structured. We saw several huddles/handovers throughout the day with medical staff and multi-disciplinary teams. Some were well facilitated, involved all the key people with a clear format. Some did not involve all key people or follow a structured format, using a recognized tool such as using a situation, background, assessment, recommendation (SBAR) tool that is used to facilitate prompt effective communication between key people.

Is the service well-led?

Requires Improvement 

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

Leadership

The director of midwifery and associate medical director were new to the role of running the service. They understood the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. However, they were at the early stages of implementing all changes required to improve the service.

The maternity service sat within the Family and Women's Health Care group. The service was led by a triumvirate, comprised of an associate medical director, the director of midwifery/assistant director of nursing and associate director of operations. There was one lead for obstetrics/ gynaecology and a lead for paediatrics/NICU. To support the leadership team there was a deputy head of midwifery and specialist lead matrons, lead nurses and midwives, teams of ward managers, midwives, specialist midwives and co-ordinators.

The director of midwifery (DoM) met with the director of nursing who had access to the board. The DoM did not have direct access to present regularly to the board. The 'Spotlight on Maternity' March 2016 states 'to ensure that there is a board-level focus on improving safety and outcomes in maternity services organisations should provide the opportunity for the Medical Director for maternity and the Head of Midwifery to present regularly to the board.' Maternity services did not have a head of midwifery in post (although this post was due to be filled in January 2022); therefore, it would be good practice for the director of midwifery to present to the board instead. The DoM was a new role for the organisation and the new DoM commenced in June 2021. Integration of this new role within the Board reporting structure was evolving to ensure best practice.

The maternity safety champion role had not been fully established and embedded. The role had been adopted to promote the professional cultures needed to deliver better care and help to ensure mothers and babies are kept safe in maternity services. During our inspection, we saw maternity safety champion posters displayed to inform staff of the maternity safety champions. However, staff we spoke with were not aware of the role of maternity safety champions and did not feel engaged with the safety champion implementation process.

Vision and strategy

Maternity

The service had a vision for what it wanted to achieve and a strategy to turn it into action in development with other relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff were not at the point where the vision and strategy were fully understood by all or to monitor progress.

The service strategy was dated 2020-2030 and outlined the vision and goals for the service over the following ten years. The strategy outlined a model of care where the service focus would be on improving pathways, building capacity and capability and providing high quality care for women. Leaders told us that it was still in draft form and required some changes to ensure inclusive language and a glossary.

Culture

Staff did not always feel respected, supported and valued. However, they were focused on the needs of patients receiving care despite their challenges. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The service had gone through recent changes in leadership, a pandemic and staffing issues that impacted on staff morale and wellbeing.

Staff were friendly, helpful to each other and to women who used the service. We saw them being warm and kind in all their interactions and observations. Staff at all levels were clearly concerned about staffing levels and impact on their ability to safely carry out their jobs to keep women and babies safe and staff morale. Staff were visibly tired, some burnt out and some tearful. Staff did not always feel listened to or supported. Staffing shortages were often escalated but there was a sense of a lack of consistent support and being left to continue without adequate breaks and staff cover. This meant some staff were concerned about the safety of everyone involved in the service.

Governance

Leaders did not operate effective governance processes throughout the service.

The service employed an audit midwife and a medical obstetric audit lead. A gynaecology matron had oversight for audit and governance. This meant there were staff responsible for the audit system for improving standards of clinical practice.

The maternity safety champions were newly in post and not yet established. Staff at all levels were unclear about the role of the maternity safety champions and the function remained outstanding.

Staff did not consistently facilitate robust, well-structured handovers and safety huddles using recognised tools. This approach would have demonstrated information shared about women with colleagues was discussed, documented and used appropriately to keep people safe.

We reviewed 43 incidents recorded for March and April for obstetrics via the national reporting and learning system. There were six PPH incidents graded as low harm where massive haemorrhaging was indicated. The incident reporting system did not record a narrative to rationalise the grading.

Management of risk, issues and performance

Maternity

Leaders and teams did not always use systems to manage performance effectively. They did not always escalate relevant risks and issues to reduce their impact. They did however have plans to cope with unexpected events.

Leaders used a risk register to record and manage risks using the trust's electronic risk reporting system. We looked at the risk register and recorded risks were dated and had been reviewed. The risks were reviewed at the monthly maternity risk meetings and the Patient Safety and Quality Forum. This meant risks were reviewed at local and wider meetings for learning and improvement.

Safety huddles were not structured to facilitate the exchange of safety focused information and membership did not always include appropriate attendance of staff required to help keep people safe. This meant we could not be assured that staff would have received detailed safety information to keep people safe.

Leaders did not provide a safe and efficient triage system for staff. Staff were not provided with guidance or training to safely and effectively manage women who were triaged over the telephone.

Medical staff reported that they did not have regular sight of the maternity dashboard which meant they were not fully aware of ongoing safety issues or key performance indicators to help keep people safe.

A locum doctor was responsible for risk management of governance. Substantive medical staff raised concerns in terms of lack of continuity by having a locum responsible for risk management of governance. This could impact on patient safety, team function and overall governance by having a temporary medic in post.

Following the CQC inspection report in 2019, the trust improved compliance with saving babies lives care bundles surrounding plotting fetal growth from 24 weeks. Figures remained below expected levels at 67% in October 2020, however improvements were demonstrated via audits and remained as a risk on the risk register

Staff carried out regular skills and drills to help them plan for unexpected events. For example, an unannounced baby abduction exercise where staff had to respond to someone trying to access the wards without authority. This was well managed by staff and managers expressed confidence in staff using the skills and drills to help them cope with unexpected events.