

The Rotherham NHS Foundation Trust

The Rotherham NHS Foundation Trust










Quality Report

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

Ratings

Overall rating for this hospital	Requires improvement 
Urgent and emergency services	Requires improvement 
Medical care	Requires improvement 
Surgery	Requires improvement 
Critical care	Requires improvement 
Maternity and gynaecology	Requires improvement 
Services for children and young people	Inadequate 
End of life care	Good 
Outpatients and diagnostic imaging	Good 

Summary of findings

Letter from the Chief Inspector of Hospitals

The Rotherham NHS Foundation Trust provides both acute hospital and community-based health services. The trust served a population of over 257,600 people living in Rotherham and the surrounding areas. In total the trust had 481 beds.

Rotherham is an urban area with a deprivation score of 53rd out of 326 local authorities (with one being the most deprived). This means that Rotherham has a significantly deprived population and is worse than the national average on a range of population health measures.

We inspected The Rotherham NHS Foundation Trust as part of our comprehensive inspection programme. We carried out an announced inspection of Hospital between 23-27 February 2015. At the same time as this inspection, an inspection of the quality and effectiveness of the arrangements that health care services have made to ensure children are safeguarded was also taking place. These inspections are part of a national programme that the Care Quality Commission is currently undertaking. The inspections review health services within local authority areas in England and will case track individual children in each area. We have used some of the information that was identified during this review within our report.

In addition, an unannounced inspection was carried out on 7 March 2015. The purpose of the unannounced inspection was to look at the children's ward and medical admissions unit at the Rotherham Hospital.

Overall, we rated this trust as "Requires Improvement" and we noted some outstanding practice and innovation. However improvements were needed to ensure that services were safe, effective, responsive and well led.

Our key findings were as follows:

Cleanliness and Infection Prevention and Control

- The trust had a dedicated infection control team. They visited the wards at Rotherham Hospital on a daily basis and were highly regarded by the staff we spoke with. The infection control team undertook a range of infection control audits on the wards.
- We saw that side rooms were used for patients who had, or it was suspected, that patients had infections. Signage to alert staff and visitors of the risk of infection was placed on the doors. On many wards we saw that the doors to these rooms were open, which meant the signage to alert of the possible risk of infection were not immediately evident. Opened doors also increased the spread of infection. We asked to see if there were risk assessments in place for doors to remain open but they weren't available.
- We saw there was clear information displayed or provided regarding the use of segregated toilets for the sole use of patients who had, or were suspected of having infections, but segregated use was not enforced. We observed toilets meant for sole use being used by patients who were not considered as being an infection risk. This increased the risk of the spread of infection.
- We saw many good examples of staff delivering care using best practice but also saw examples where staff action increased the risk of infection. This included one staff member who cleaned a toilet and left the toilet without removing their gloves and aprons and entered a clean area.
- The incidence of *Clostridium difficile* infections in 2013/2014 was 29 and was above the trusts target.
- There had been no Methicillin-resistant *Staphylococcus Aureus* (MRSA) infections across the trust in the last 12 months.
- During our inspection we found that generally the hospital was visibly clean.

Nutrition and Hydration

- Nutritional screening assessments were available in all patient records that we looked at.

Summary of findings

- Patients generally reported that the quantity of food was sufficient but there were variable reports on the quality with most patients telling it was acceptable. Following the inspection, the trust changed its catering contract and it was hoped this would bring new benefits to both staff and patients.
- Where patients had identified nutritional needs, staff were alerted to this by the use of a red napkin and red jug being placed on their tray. Most patients had the appropriate coloured jug by their beds.
- Protected meal times were in place to allow time for patients to eat sufficiently. Where relatives or friends supported people to eat, they were encouraged to continue this.
- Most fluid balance charts we saw were well completed, however the audits on some wards identified that they were at times poorly completed.

Mortality

- There were no open mortality outlier alerts for the trust at the time of our inspection. Mortality outlier alerts look at patterns of death rates in NHS trusts. Alerts are issued when the number of deaths is higher than usual.
- The trust reported data for the 'Summary Hospital - level Mortality Indicator' (SHMI). The summary hospital-level mortality indicator (SHMI) and the hospital standardized mortality ratio (HSMR) between July 2013 and July 2014 shows no worse than the national average for the number of deaths. The groups with highest excess deaths for the latest SHMI were pneumonia, stroke, mental retardation and senility, renal failure and lung cancer. SHMI and HSMR are ways in which the NHS measures healthcare quality by looking at the death rates from certain conditions in a trust.
- The trust held monthly mortality review meetings where all unexpected deaths were reviewed.

Staffing

- Planned staffing levels were not being achieved on a number of wards, particularly those in the medical care service. This was impacting heavily on staff morale, sickness and retention. The trust recognised this and recruitment, including overseas recruitment was underway.
- The trust was reliant on agency nurses, but tried to use the same agency staff where possible. We were encouraged to see the nurse staffing reports to the trust board and to the Quality Assurance Committee explored the potential for a link between nursing vacancy rates and the incidence of patient falls. A correlation had not been confirmed.
- Medical staff were in a better position than nurses, although there were some areas of the trust that required an increase.

We found areas of good practice.

- BreathingSpace was an innovative nurse-led unit. The unit had been visited by members of parliament as well as interested parties from across the UK, Japan, China and Belgium. The nurse consultant who led the unit had presented papers at national and international conferences focused on respiratory illnesses.
- BreathingSpace provided exemplary care to the patients it cared for due to the highly skilled and knowledgeable staff working on the unit. Staff were caring and compassionate and continued their caring role by supporting families after the loss of a loved one. It was an example of an innovative community service that met the needs of the population very well.
- The trust hosted a photopheresis treatment service which helped patients with conditions where the white blood cells are thought to be the cause of the disease. It is the largest centre outside of London to provide the treatment. We saw a child who had travelled some distance for the treatment during our visit. It was a service that was highly valued by the patients who used it.

We also found areas of poor practice where the trust needs to make improvements.

Importantly, the trust must ensure that:

Summary of findings

- All relevant staff have received appropriate training and development. This should include, mental capacity, safeguarding adults and children, resuscitation and living with dementia awareness.
- All relevant staff are able to assess the capacity and best interests of patients in line with the Mental Capacity Act 2005 and its associated deprivation of liberty safeguards.
- All do not attempt cardio-pulmonary resuscitation (DNA CPR) forms are completed in line with the trust's policy and that patients' capacity is assessed in line with the requirements of the Mental Capacity Act (2005).
- The registered person must ensure patients are not cared for in mixed sex wards/departments apart from those areas which are exempt from meeting the national requirements.
- There are sufficient number of suitably skilled, qualified and experienced staff.
- The outpatient appointment validation process is completed and actions taken to assess clinical risks to patients of having overdue appointments.
- The registered person must ensure the environmental risks on the children's ward are assessed and mitigated so that it is safe and secure.
- They report and investigate incidents in a timely manner and that learning is shared with all staff.
- Directorate and corporate risk registers are reviewed so they reflect the current identified risks, contain appropriate mitigating actions and that the risks are monitored and reviewed at appropriate intervals.

In addition the trust should:

Emergency department

- Complete a review of staffing levels so appropriate numbers of suitably qualified nurses, emergency department assistants, and healthcare assistants are on duty to manage surges in demand.
- Ensure that all relevant staff are able to attend regular staff meetings.
- Ensure that there are systems in place that allow for professional sign language interpretation of consultations for profoundly deaf patients who use sign language, either in person or via video link.

Surgery

- Improve the 18-week referral-to-treatment targets so that patients have access to timely care and treatment.
- Improve access and flow for patients attending fracture clinic appointments.
- Minimise the movement of patients from other specialities onto surgical wards, particularly those wards providing elective orthopaedic surgery.

Critical care

- Make sure that staff have access to up-to-date, evidence-based guidance.
- Review access to the intensive care unit so it is secure at all times.
- Ensure that consultant ward rounds take place in accordance with national guidance.

Maternity

- Review guidance so that the time intervals for recording patient observations are sufficiently frequent to ensure patient safety.
- Review documentation so that appropriate prompts are available to identify patient safety needs.
- Review the process for women with social service involvement, who may require an extended stay on the ward after giving birth.
- Review the rates of elective caesarean section and those performed following an induction of labour, with appropriate implementation of identified learning.

Summary of findings

- Review access and patient flow on the labour and postnatal wards so there is effective use of resources to ensure that mothers and babies are cared for in the most appropriate place.

Children and young people

- Review the internal safeguarding processes and implement identified actions.
- Review the transition arrangements for children and young people for all pathways.
- Review the leadership of the service so there is access to senior children's nursing advice.

Outpatients and diagnostic imaging

- Ensure that sharps are managed in a manner which protects staff and patients from the risk of needle-stick injuries.

Hospital wide

- Ensure that information about how to make a complaint or leave a comment is available in alternative formats and languages.
- Ensure that nursing staff have access to clinical supervision.
- Ensure that patients who are living with dementia and/or their relatives have the opportunity to give information about their personal circumstances, their preferences and likes and dislikes.
- Patients' records are kept securely at all times.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Requires improvement



Rating

Why have we given this rating?

Overall we rated the urgent and emergency services as 'requiring improvement'.

The design of the A&E department was not suitable for the number of patients. This was acknowledged by the trust and the commissioners and future plans were in place for the expansion of the department. Sick patients could be forgotten at busy times if they were in areas which were not always under direct observation. Department staff felt that there were not enough nursing staff available to safely deal with surges in demand. We were told that the department was recruiting to bands 5, 6 and 7 nursing posts (band 7 being the most senior operational position in the department). There was one vacancy, a band 7 post, at the time of the inspection. There were not enough substantive middle-grade doctors to provide a consistent level of service, with cover provided by temporary locum staff. The facilities for children were small and cramped and were in areas which members of the public could readily access without challenge. This created a safeguarding risk for children.

Audits were regularly undertaken to assess the effectiveness of the clinical work of the A&E department. We found that guidelines for the treatment of different clinical conditions had not been reviewed for up to seven years. This created a risk of patients not receiving the most up-to-date and effective care.

Patients were treated by staff in a caring and understanding manner, taking into consideration social and holistic needs. However, the design of the department, especially the size of the triage room facing the waiting room, made it difficult for staff to always protect patients' privacy.

The trust failed to meet the target in quarters three and four of 2014/15 for at least 95% of patients attending A&E must be seen, treated, admitted or discharged in under four hours in. However, it did meet this target earlier in the year. There were systems in place to manage the target and improve patient flow. Staff felt that it would not be possible

Summary of findings

to achieve full compliance with the target until the service moved to the new Emergency Centre, which would be better designed to meet patients' needs in a more timely manner.

Over the winter months, there had been an upsurge in attendances from acutely ill patients with complex health needs at Rotherham, but also across all healthcare services, making it difficult to divert patients to other A&E departments.

Although there were systems to provide translation support for patients whose first language was not English, similar systems were not in place for patients who were profoundly deaf and used sign language. This could lead to a situation where such patients could receive a less-effective or less-efficient service than other patients.

Staff felt they were well-led at departmental and trust level. However, there was little evidence of engagement with staff through team meetings or monthly quality meetings. Although all staff groups were invited to these meetings, nursing staff found it difficult to attend because of the pressure of workload.

The only areas of innovation and improvement were around the creation of the new Emergency Centre. There was a general belief that this would help end the pressures that were difficult to manage in the present A&E department.

Medical care

Requires improvement



Overall we rated the medical care as "requiring improvement."

Staff shortages were evident and planned staffing levels were not being achieved on many wards. This was impacting heavily on staff morale, sickness and retention. The trust recognised this and recruitment, including from overseas, was underway.

Mandatory training levels were poor and there was not a proactive or structured approach to delivering training. There was little awareness or practical application of the Mental Capacity Act 2005 or its associated deprivation of liberty safeguards. There was a risk that patients may be unlawfully deprived of their liberty.

Summary of findings

Wards and equipment were not always clean. Where patients were infectious or suspected of having an infection, practices and procedures did not always protect against the risk of spreading infection.

Where patients were at risk of tissue breakdown, we saw that there was not always equipment available or provided for them.

Pressure on beds meant the discharge lounge was being used as an inpatient ward during our visit. This was discussed with the trust, and they told us the lounge was due to close which it subsequently was. Patient flow through the hospital was affected by bed availability, however, referral -to -treatment times at the trust were being met.

There was little knowledge or evidence of dementia care planning in patients' records. Dementia screening was undertaken but, in practice, this had little effect on improving care for patients. Few staff were trained in dementia care.

Patients told us that staff were caring but it was recognised that they were under pressure due to staff shortages. Patients and visitors told us that staff were "rushed off their feet" but always delivered care in a kindly way with a smile.

Staff treated people with dignity and respect and patients told us that staff were "lovely, caring and friendly". There was a significant amount of mixed-sex breaches where male and female patients shared the same bed bays. These were commonplace on ward B1 and staff were increasingly tolerating this as acceptable practice even though rearranging the beds could alleviate this for some patients.

Surgery

Requires improvement



Overall, we rated surgical care as "requiring improvement."

The directorate was responsive to patients' individual needs, but there were concerns over waiting times, such as the 18-week referral-to -treatment times, the high number of medical outliers on surgical wards, access and flow for patients attending the fracture clinic and mixed-sex accommodation breaches on the surgical assessment unit.

Summary of findings

There had been one Never Event (a serious, largely preventable patient safety incident that should not occur if proper preventative measures are taken) in surgery in the last 12 months (January – December 2014). This related to a retained surgical pack. However, the ‘five steps to safer surgery’ procedures (an adaptation of the World Health Organization’s surgical safety checklist) were not completely embedded in theatres. There were mechanisms in place to manage incidents and monitor some of the safety aspects of wards, such as specific patient harms. However, we found that some staff were not confident in their explanations of the reporting mechanisms. Most staff received feedback following incidents.

Nursing staff levels were not always maintained as planned. However, the arrangements in place ensured that a sufficient number of skilled and knowledgeable staff were on duty to safely meet patients’ needs. The trust was actively recruiting nurses to fill vacancies.

The care and treatment of patients followed evidence-based best practice and professional standards. Surgical outcomes were generally good and were monitored.

Most patients we spoke with were positive about the care they received from staff. Patients felt their dignity and privacy were respected and described staff as “kind and caring”. Patients’ nutrition, hydration and pain relief needs were met appropriately.

The current senior leadership team had a good understanding of their roles within the directorate and were aware of the risks and developments required to improve patient care. A number of developments were being implemented; however, it was too early to say whether these would be effective and sustainable.

The directorate had governance structures in place and took part in clinical audit and clinical effectiveness programmes to try to improve the quality of care delivered by the hospital. However, governance frameworks were not yet fully embedded and work was on-going to ensure that robust processes were in place. Patient and staff engagement was improving.

Summary of findings

Critical care

Requires improvement



Overall we rated the critical care service as "requiring improvement."

There were concerns that a poor incident-reporting culture existed within the department, with little evidence of sharing or learning from incidents or complaints.

The trust did not always meet the recommendations of the core standards for medical and nurse staffing in intensive care units. There were not enough critical care specialist consultants to provide 24-hour cover and specialist nursing supernumerary support was not always possible. Security of the department was highlighted as a concern due to open access during the daytime hours.

The environment was clean and staff followed infection control procedures. NHS Safety Thermometer data indicated good patient outcomes with below average infection rates and no medication errors.

There was a lack of accessibility to current policies and guidelines which had led to use of custom and tradition rather than evidence-based best practice. Insufficient specialist critical care consultants resulted in patients not receiving specialist reviews within the timescales outlined in the critical care core standards.

The critical care service was generally effective in meeting patients' needs and the data available indicated that results were in line with the activity and outcomes of similar-sized units.

A recent high turnover of nursing staff meant there was a high percentage of newly qualified or inexperienced staff. The practice development nurse was sometimes allocated a patient to care for, resulting in reduced supervision of new staff.

The inspection team observed staff delivering care to patients and witnessed a caring and compassionate approach on every occasion. We spoke with patients and carers about their experiences on the critical care unit and found all their responses to be positive. The unit could access interpreters and multid denominational pastoral support when needed.

Summary of findings

The department was a member of the North Trent Critical Care Network and had adopted the network's admission, transfer and discharge policies. The average length of stay in the unit was consistent with other similar-sized units. Complaints and concerns were dealt with at senior management level. We saw no evidence that complaints or concerns were discussed at staff meetings or that any changes had been made in response to a concern or complaint. There was no clear vision for the future development of the department. The risk register was not fit for purpose and was found to include risks that dated back to 2010, without a clear outcome from actions.

Maternity and gynaecology

Requires improvement



Overall we rated the maternity and gynaecology service as "requiring improvement." We were concerned about staffing levels in each area of the maternity department. We were told by staff that there were insufficient staff allocated to each shift and that, on occasions, shifts were below the trust's minimum requirement, either due to sickness or because midwives were transferred from the combined antenatal/postnatal ward to work on the labour ward, leaving their own ward short of staff. The trust had a system to report and investigate incidents. Some staff informed us that they did not always have time to report incidents, particularly about short-staffing and, the busier the department, the harder it was to find time to do so. We saw evidence that lessons had been learned from incidents reported and that these were shared with staff. Arrangements for assessing and responding to patient risk were insufficient and there was a risk that patient safety needs may be overlooked because appropriate prompts were not included on all documents. Mandatory training levels were below the trust's target for all staff groups. Safeguarding arrangements were in place, although improvements were needed for completion of documentation. The process needed to improve for women with social service involvement who had delivered their baby and may require an extended stay on the ward.

Summary of findings

There was a system to audit the care and services provided. While it was identified through audit that some standards had improved, others had not and were still poor compared to the England averages. Outcomes for women were variable. There was a high rate of births being induced and of emergency caesareans – both rates were significantly higher than the England average. The perineal tear rate fluctuated and was very high some months, with no consistent upward or downward trend. The number of maternal readmissions was also high. We saw that some midwives were responsible for providing care for women recovering from surgery, but they had not received an adequate level of training to do so. There was a lack of midwives trained to perform basic tasks, for example, suturing and cannulation, as well as new-born baby checks. This impacted on the patient flow in the department as a limited pool of staff were relied on.

We saw that women received pain relief as required and adequate arrangements were in place to ensure women and their babies received nutrition and hydration. Seven-day services and multidisciplinary team working was good and staff had an understanding of the Mental Capacity Act 2005.

The women and relatives we spoke with all reported that they received a good standard of care from all members of staff. Women told us that staff were caring although busy and that information about their treatment had been explained to them. We saw, and were told, that the maternity department was often very busy and that staff did not always have time to provide individualised care. The acuity of women was high and a large number had social needs. This meant that more time needed to be dedicated to a significant proportion of the women who attended the hospital.

There was a clear governance structure in place, although action plans could be clearer to ensure that these were followed up. The accuracy of discussion around performance could be improved to ensure it reflected the performance being achieved and any required action agreed and documented.

Summary of findings

There were clearly defined accountability arrangements and staff felt well-supported by their immediate line manager, although some commented that they rarely saw senior managers on the wards or in the community.

Services for children and young people

Inadequate



The children's and Young People's service was inadequate.

We found a number of environmental safety concerns, particularly for patients with mental health needs cared for on the children's ward. We raised concerns at the time of inspection and the trust took immediate action to mitigate as many of the risks as possible.

The staffing establishment fell below nationally recognised guidelines on the children's assessment unit, ward and special care baby unit (SCBU). Concerns about the assessment unit and the ward were raised at the time of inspection and the trust took immediate action to improve staffing levels.

There was a concern that patients could be at risk because safety concerns were not identified or dealt with appropriately and in a timely manner. The approach to safety was inconsistent and information about safety was not comprehensive and learning was not shared widely.

There were appropriate systems for safeguarding and staff understood their responsibilities for reporting safeguarding concerns externally. However, reporting of safeguarding issues internally was less robust and not all staff had received training.

Children and young people's needs were assessed appropriately with care and treatment delivered in line with current legislation. There was limited evidence to identify how the department took assurances that the clinical interventions they performed resulted in positive patient outcomes. Staff were not always supported to participate in training and development which would enable them to deliver good quality care. Staff had not had training on the Mental Capacity Act 2005 or training to enable them to provide support and care to children who had mental health needs. We raised this during our inspection and the trust took

Summary of findings

immediate action. At the unannounced inspection, training had been arranged for Child and Adolescent Mental Health Services (CAMHS) awareness training for all staff to attend. Services were not always delivered in a way that met the needs of the children and young people, such as children who had mental health problems. The approach to meeting the needs of different groups of children could be reactive rather than proactive. The hospital had no formal adolescent transitional arrangements in place to facilitate transfer between child and adult services. The vision and values for the service were not well-developed or established. Governance arrangements were unclear and provided limited assurance in identifying and managing risks and concerns. There was a limited approach to risk management and it was unclear who was responsible for reviewing and managing identified risks. The trust did not have access to a senior children's nurse at all times.

End of life care

Good



Overall, we rated the End of Life service as good. We checked 35 DNA CPR forms on wards throughout the hospital and found they were completed inconsistently. This mainly related to how the capacity of patients unable to make decisions about DNA CPR was assessed. The trust had replaced the Liverpool Care Pathway for delivering end of life care with individualised care plans for patients. Patients approaching the end of life were identified appropriately and care was delivered according to their personal care plan, including effective pain relief and other symptoms which were regularly reviewed. Patients in the last days of life were identified in a timely way and appropriate action was taken. Patients' pain was well-managed and appropriate prescribing was in place to manage symptoms such as nausea and vomiting or agitation. We saw that patients were treated with compassion, dignity and respect. Patients and their

Summary of findings

representatives spoke positively about their care and told us they felt included in their care planning. We also observed a caring approach by the mortuary and bereavement staff.

The trust did not have a rapid response policy for end of life care patients who preferred to die at home. However, we were told that this could be facilitated within two to three hours with the support of the hospice rapid response team, the trusts specialist palliative care team and the continuing healthcare team. The trust did not collect this data so we were unable to corroborate this. Data from the trust stated that 93% of patients on the end of life care pathway had died in their preferred place in the last year.

There was a multi-faith prayer room, with screens to separate men and women to accommodate those of Muslim faith. The responsiveness of mortuary and bereavement staff to the needs of parents who had lost children or babies was an example of good practice.

There was a vision and strategy for the end of life care service. There was an increase in investment and staff to support a seven-day, face-to-face service by the specialist palliative care team (SPCT).

The trust had a specialist palliative care clinical governance group which provided a forum for clinical governance development, implementation and monitoring across the hospital's specialist palliative care services. There was an executive director who was the lead for end of life care.

Risk management and quality assurance processes were in place at a local level. The end of life service held governance and patient safety meetings and records showed that risks were escalated, included on risk registers and monitored each month.

Staff within the SPCT spoke positively about the service they provided for patients and were passionate about their work. The mortuary and bereavement staff culture was very positive and enthusiastic about the provision of care at the end of a person's life. This was demonstrated through their approach to patient care.

There were no specific consultation groups for patients and the public to contribute to the development of end of life care services in the trust.

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The SPCT acknowledged that there was work to be done to improve end of life care services throughout the trust and had compiled a five-year plan to address this.

Outpatients and diagnostic imaging

Good



Overall we found that outpatients and diagnostic and imaging departments as good. We found that safety was good, incidents were reported and risks to patients were assessed. Processes and procedures were in place according to national guidance and regulations. Infection control and cleanliness of equipment was of a good standard. However there were challenges regarding staffing in outpatients and diagnostic imaging, but plans were in place to respond accordingly. Data from the trust showed that there were low completion rates for safeguarding and mandatory training were low. There was little evidence that Mental Capacity Act training had taken place. Staff were able to demonstrate evidenced- based care and treatment, monitoring of patient outcomes and there was good multi-disciplinary team working. Staff were caring and we saw positive interactions between staff and patients. There were good initiatives and care pathways for patients and services were responsive to people's needs. Referrals were managed well by booking staff, however, we saw that some patients had been waiting nearly two years for follow- up appointments. The environment presented significant challenges for outpatient and diagnostic imaging departments. Patient flow between departments was affected by a lack of space and other departments being situated on different floors. Waiting areas were small in main outpatients and staff said that they had "outgrown" the space they were in. However, there were plans were in place to address this through the estate's strategy and staff worked well and used the space as best they could. Services were well- led at department level. Staff felt supported by their managers. There was a positive view of the chief executive and the majority of staff shared the management visions for the services. There was a new governance arrangement which was evolving, and there was a positive

Summary of findings

culture which encouraged teamwork and collaboration. However, there were concerns regarding escalating issues to senior management, bureaucracy and the lack of response to issues.

The Rotherham NHS Foundation Trust

Detailed findings

Services we looked at

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

Detailed findings

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Background to The Rotherham NHS Foundation Trust

The Rotherham NHS Foundation Trust is a district general hospital. The trust was authorised as a foundation trust by Monitor in 2005. An NHS foundation trust is still part of the NHS but the trust has gained a degree of independence from the Department of Health. The

hospital provided a full range of hospital services, including an emergency department, critical care, and general medicine, including elderly care, general surgery, paediatrics and maternity care.

Our inspection team

Our inspection team was led by:

Chair: Dr Jane Barrett, Chair Thames Valley Clinical Senate

Head of Hospital Inspections: Carolyn Jenkinson, Head of Hospital Inspection, CQC

The team included two CQC inspection managers, 12 CQC inspectors and a variety of specialists including: consultant surgeon, consultant in respiratory medicine, a consultant paediatrician, consultant intensivist, a GP, a

student nurse, two midwives, two executive director nurses, a governance expert, an occupational therapist, a speech and language therapist, a matron, two community adult specialist nurses, one health visitor, one school nurse, a physiotherapist, a head of children's nursing and a dentist. We were also supported by two experts by experience who had personal experience of using or caring for someone who used the type of services we were inspecting.

How we carried out this inspection

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

- Is it safe?
- Is it effective?

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

Before our inspection we reviewed a wide range of information about the Rotherham NHS Foundation Trust

Detailed findings

and asked other organisations to share the information they held. We sought the views of the clinical commissioning group (CCG), NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch team.

We held a listening event in Rotherham on 17 February 2015 where members of the public shared their views and experiences of the trust. We also held focus groups with members of the public. Some people also shared their experiences of the trust with us by email and telephone.

The announced inspection of Rotherham Hospital took place between 23 and 26 February 2015. We held focus groups with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student

nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas, outpatients services as well as in the community services. We observed how people were being cared for, talked with carers and family members, and reviewed patients' records of personal care and treatment.

We carried out an unannounced inspection on 7 March 2015 at Rotherham Hospital. The purpose of our unannounced inspection was to look at the children's ward and the medical assessment unit.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment delivered by the trust.

Facts and data about The Rotherham NHS Foundation Trust

The Rotherham NHS Foundation Trust provided integrated services to a population of 257,600 patients. It had a total of 481 beds: 427 general and acute; 39 maternity; two children's critical care; 13 adult critical care.

The trust employs: 3552.8 whole time equivalent (WTE) staff.

The trust has a total revenue of £242.71 million and its full costs were £242.57 million. It had a surplus of £0.14 million.

There were 69,788 inpatient admissions between 1 November 2013 to 31 October 2014; 238,577 outpatient (total attendances) and the A&E department saw 76,260 patients between December 2013 and November 2014.





Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Inadequate	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Critical care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Services for children and young people	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
End of life care	Good	Requires improvement	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

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

Information about the service

The accident and emergency (A&E) department at Rotherham Hospital is the local A&E department for people who live in Rotherham and the surrounding areas. It treats all accidents and emergencies except for adult major trauma and children's major trauma which is taken to other hospitals.

In 2014, the A&E department saw 74,172 patients. About 20% of attendances were under the age of 16. The department was originally built for 55,000 attendances but was currently seeing in excess of 74,000 people. During our inspection, we spoke to around 37 patients, 13 relatives and 42 staff. We observed care and treatment being undertaken. We also reviewed more than 50 clinical records, policies and procedures.

The inspection team for the A&E department included a CQC inspector and three specialist advisors with significant clinical and managerial experience in urgent and emergency services.

Summary of findings

Overall we rated the urgent and emergency services as 'requiring improvement'.

The design of the A&E department was not suitable for the number of patients. This was acknowledged by the trust and the commissioners and future plans were in place for the expansion of the department. Sick patients could be forgotten at busy times if they were in areas which were not always under direct observation. Department staff felt that there were not enough nursing staff available to safely deal with surges in demand. We were told that the department was recruiting to bands 5, 6 and 7 nursing posts (band 7 being the most senior operational position in the department). There was one vacancy, a band 7 post, at the time of the inspection. There were not enough substantive middle-grade doctors to provide a consistent level of service, with cover provided by temporary locum staff. The facilities for children were small and cramped and were in areas which members of the public could readily access without challenge. This created a safeguarding risk for children.

Audits were regularly undertaken to assess the effectiveness of the clinical work of the A&E department. We found that guidelines for the treatment of different clinical conditions had not been reviewed for up to seven years. This created a risk of patients not receiving the most up-to-date and effective care.

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Patients were treated by staff in a caring and understanding manner, taking into consideration social and holistic needs. However, the design of the department, especially the size of the triage room facing the waiting room, made it difficult for staff to always protect patients' privacy.

The trust failed to meet the target in quarters three and four of 2014/15 for at least 95% of patients attending A&E to be seen, treated, admitted or discharged in under four hours. However, it did meet this target earlier in the year. There were systems in place to manage the target and improve patient flow. Staff felt that it would not be possible to achieve full compliance with the target until the service moved to the new Emergency Centre, which would be better designed to meet patients' needs in a more timely manner.

Over the winter months, there had been an upsurge in attendances from acutely ill patients with complex health needs in Rotherham, but also across all healthcare services, making it difficult to divert patients to other A&E departments.

Although there were systems to provide translation support for patients whose first language was not English, similar systems were not in place for patients who were profoundly deaf and used sign language. This could lead to a situation where such patients could receive a less effective or less efficient service than other patients.

Staff felt they were well-led at departmental and trust level. However, there was little evidence of engagement with staff through team meetings or monthly quality meetings. Although all staff groups were invited to these meetings, nursing staff found it difficult to attend because of the pressure of workload.

The only areas of innovation and improvement were around the creation of the new Emergency Centre. There was a general belief that this would help end the pressures that were difficult to manage in the present A&E department.

Are urgent and emergency services safe?

Requires improvement



The safety in the A&E department required improvement. The design of the department was not suitable for the number of patients. Some areas where sick patients were cared for were not visible to clinical staff. Some of the rooms were too small and posed a risk to patients and staff. Access to the department was not controlled and members of the public could walk through the department. Children had to walk through the adult waiting area to get to other parts of the department such as x-ray.

Staff did not feel there were enough personnel working in the department, particularly when it was busy. We were told that the department was recruiting to bands 5, 6 and 7 nursing posts (band 7 being the most senior operational position in the department). There was one vacancy, a band 7 post, at the time of the inspection. Planned nurse staffing levels were mostly met.

Although there were sufficient numbers of consultant medical staff to meet College of Emergency Medicine (CEM) guidance for 16-hour consultant cover, there were not enough substantive middle-grade doctors to consistently cover the department. Locum doctors provided middle grade cover.

The evidence showed that mandatory training levels were low, particularly for nursing and medical staff but this contradicted what staff told us. The system used to capture training was not accurate.

Reception staff routinely checked whether a child or young person attending the department was in care (looked-after) or was the subject of a child protection plan.

Incidents

- Staff were aware of the trust's incident reporting system and knew how to report incidents.
- Between 1 August and 30 November 2014, 72 incidents were reported on the electronic reporting system: 14 were awaiting review; the remainder had been reviewed; and there was evidence of lessons learned.
- Incidents were discussed at monthly departmental quality governance meetings, which all staff were invited to attend. There were standing agenda items for

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patient safety and discussions of the risk register report and of mortality and morbidity issues. There had been one serious incident involving the safeguarding of a child in October 2014. A discussion of the learning from this incident occurred at the A&E quality governance meeting which took place in January 2015.

Cleanliness, infection control and hygiene

- Infection control was a standing agenda item on the monthly departmental quality governance meetings. At the meeting held on 10 February 2015, infection control rates were discussed.
- In July 2014, the lead nurse for infection control and the head of facilities undertook a full audit of infection control standards in the department. Compliance was set at a percentage score of 85% or above. The department scored 100% except in the area of the general environment where there was a score of 93.7%. It was assessed that the waiting room floor and other areas needed to be refurbished. During our inspection, we also saw that the main waiting area floor was worn. There was a longer-term plan for a full refurbishment of the department.
- Staff in the department undertook infection control audits. These included audits of department equipment – for example, a commode audit was undertaken in September 2014. We also reviewed an audit of the management of waste in the clinical decisions unit undertaken in December 2014. The equipment we inspected appeared to be clean.
- We found hand gel containers throughout the department and observed staff using them.
- We saw a spillage on the floor beneath one of the waiting area seats which was identified as vomit. We informed the matron for unscheduled care and, shortly after, domestic staff cleaned the area. Unfortunately, people had been sitting in this area, creating a risk of cross-infection of bodily fluids.
- We found that the public toilets adjacent to the waiting room were clean.

Environment and equipment

- The design and layout of the department was not suitable for the number of patients. There was a risk to safety because patients could be placed in areas which were not always under the observation of clinical staff. On various occasions we saw patients being overlooked

when they were in parts of the major injuries (Majors) area – where some of the most critical patients were treated – which were away from the central nurses' station.

- There were 16 Majors bays and four resuscitation area bays, one of which was designated for children.
- The children's waiting area was not observable by staff and was not covered by CCTV or monitored by security. It was possible for members of the public to walk into these areas without being challenged. This posed a potential safeguarding risk to children.
- It was also easy for people to wander through the department as entrances were not controlled by access codes. We observed a member of the public being dropped off in a private car by the ambulance entrance and then making their way through the department until they reached the fracture clinic.
- Children going to have an x-ray had to walk through the main department, which was undesirable.
- We found that the triage room for adult patients was very small and it presented a risk to patients and staff. We saw that, when patients in wheelchairs were assessed, the room was too small and the wheelchairs were placed in the doorway. This breached patients' confidentiality as the conversation between patient and staff could be heard by other people in the waiting room or outside the open door. This also meant that staff could not get out of the room easily as the door was blocked by the wheelchair.
- The trust informed us that arrangements were proceeding for the creation of a new Emergency Centre due for completion in 2017. They told us that this new department would be designed to fully meet the needs of all patients, including children and young people. In the meantime a service review of the environment was being undertaken alongside a review of the children's assessment unit which it was hoped may address some of the limitations of the space in the emergency department.
- We found that equipment used in the department was regularly maintained.

Medicines

- We found that controlled drugs were checked on a regular basis by qualified nursing staff.
- Some nursing staff were trained to be autonomous prescribers.

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- We found that nursing staff were able to administer medicines to patients under patient group directions (PGDs) – specific written instructions for the supply and administration of medicines to specific groups of patients.

Records

- Patient details were recorded on A&E paper records and then copied on to the Symphony electronic patient record system.
- We observed clinical and administrative staff completing patient records in a methodical manner.
- In paediatric documentation, we found there was no section to record the reassessment of pain scores, while such a section was available in the adult documentation.

Safeguarding

- Safeguarding was a standing agenda item on the monthly departmental quality governance meetings. During the meeting held in February 2015, there was a discussion of contact between parents and children.
- We found that children and young people attending A&E had their safeguarding needs assessed, with appropriate actions taken to keep them safe.
- Reception staff routinely checked whether a child or young person attending the department was in care (a looked-after child) or was the subject of a child protection plan. If that was the case, an alert was placed on their record and details were recorded of the next-of-kin or whoever was accompanying the child. This information was then passed on to clinical staff who would be assessing and treating the young person.
- The children's records contained a safeguarding questionnaire to guide clinical staff in their safeguarding risk assessment. The records we reviewed showed good compliance with completion of the questionnaire. However, in some cases, we saw no evidence of staff considering previous attendances of a child and how those related to the current presentation. Also, in one case, the member of staff had assessed that there were no safeguarding concerns when these had been clearly identified at an earlier assessment.
- A paediatric liaison nurse reviewed all attendances of children and young people under the age of 18. Although this was an additional safeguard, we identified a number of cases where issues had been missed by A&E staff and the paediatric liaison nurse. As these

issues were not picked up by any existing quality assurance or operational management system, this failure indicated that governance and quality arrangements were not sufficiently robust.

- The paediatric liaison nurse received regular supervision from the trust's named nurse for safeguarding. However, we found that the lead safeguarding clinician in A&E had not received any supervision from the trust's designated safeguarding doctor.

Mandatory training

- Training records we reviewed for the year up to November 2014 revealed inconsistencies in the mandatory training courses attended by staff. For example, 100% of estates and ancillary staff had undertaken information governance training, but only 21% of nursing staff had undertaken dementia training.
- Records also showed that 26% of medical staff and 30% of nursing staff had undertaken display screen equipment training, although use of such equipment was a daily part of their role. However, 90% of administrative and clerical staff had undertaken this training.
- For conflict resolution training, although 88% of administrative and clerical staff had undertaken this training, the numbers for nursing and medical staff were much lower. The records showed that 44% of nursing staff and 44% of medical staff had undertaken this training. This is important training for A&E staff as they are likely to come across violence and aggression as part of their work.
- For safeguarding training, the records showed that 21% of medical staff and 14% of nursing staff had undertaken level 2 safeguarding adults training, but none were recorded as having undertaken level 3 training.
- Records for safeguarding children training showed that 50% of nursing staff had undertaken level 2 training, although no medical staff had undertaken this training.
- For level 3 safeguarding children training, 70% of medical staff, 66% of nursing staff and 55% of additional clinical staff had undertaken the training.
- These records indicated that the trust was not meeting its 80% benchmark for staff completion of mandatory training. This is a matter of concern. However, the data contradicted interviews with staff who told us they had undertaken their mandatory training and found it was easy to access.

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Assessing and responding to patient risk

- We found that all patients were assessed on admission to the department. Patients arriving by ambulance were allocated by the majors' coordinator to the Majors or resuscitation areas, depending on the severity of their condition.
- We found that, when the department was busy, nurses triaging minor injuries (Minors) patients were taken away to assist in Majors. This risked a build-up of patients in the Minors area.
- Clinical risk was assessed and responded to using the patient at risk (PAR) early warning score. This allowed for the recognition, management and escalation of risk. Staff were aware of this system and knew how it operated. We reviewed PAR score data in patient records and found it was appropriately recorded.
- In the case of trauma patients, a trauma triage guide was used. This allowed for a rapid assessment based on the nature of the injury. The patient would then be allocated to the Minors or Majors areas.
- Once a decision had been made to refer a patient to the specialty teams, this was logged on the Symphony electronic patient record and in the patient's notes. The time was noted to ensure that the specialty team saw the patient within the 30-minute target time.
- We found that not all risk assessments in nursing documentation (a mandatory part of the triage assessment designed to protect patient safety) were carried out during the triage process. We reviewed five sets of notes and found that, in three of them, no risk assessment had been carried out. In one of the cases, the risk had been incorrectly identified and a high-risk factor had been given a lower grading. This was brought to the attention of the nurse coordinator who agreed with our findings.
- Nursing staff told us that patients who were immobilised as a protective measure following suspected fractures of the cervical spine were placed in cubicles opposite the nurses' station in the Majors area. If that was not possible, they would be left in a cubicle with a nurse observing them. However, we observed that an immobilised patient with a suspected fracture of the cervical spine had been left in a corridor where they were not under observation. Patients who have been immobilised to protect spinal fractures should be observed in case their condition deteriorates. Because of their immobility, they are also at risk of aspiration of

stomach contents as they are unable to vomit without help. This was reported to the nursing staff who moved the patient to a location where they could be observed appropriately.

Nursing staffing

- Nurse staffing levels were based on adapted patient dependency studies and patient assessment. These were used as a baseline for determining staffing levels on each shift.
- Most nursing staff told us that they were usually able to meet patients' needs, however, when the department was busy, staffing levels were not sufficient. During our inspection, we observed the organisation of nursing care in the Majors area and found that, when it was busy, it was difficult for the nurse coordinator to provide the necessary cover for all patients in this area. This led to nurses being taken off triage duties to assist in Majors and resulted in patients waiting longer for their initial assessment.
- The nurse staffing establishment per shift had recently been increased from six to nine qualified nurses, while healthcare assistant and emergency department assistant numbers were increased from three to five. We saw that the department met the planned staffing levels. Bank staff were used to cover annual leave or sickness.
- We were told that the department was recruiting to bands 5, 6 and 7 nursing posts (band 7 being the most senior operational position in the department). There was one vacancy, a band 7 post, at the time of the inspection.
- There were qualified members of the nursing team who worked in advanced roles as emergency nurse practitioners, treating patients with minor injuries, and advanced nurse practitioners who worked with more seriously ill patients in the majors and resuscitation areas.
- Healthcare assistants performed advanced roles such as taking blood, and also had the opportunity to train as emergency department assistants who could put on plaster casts and take electrocardiograms (ECGs), among other duties.
- Senior staff were aware of the draft National Institute for Health and Care Excellence (NICE) staffing guidance

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(Safe staffing for nursing in A&E departments, (NICE, February 2015). A report to assess the staffing levels in the unit against this draft guidance was taken to the Quality Assurance Committee in March 2015.

Medical staffing

- We found there was appropriate consultant cover arrangements which met College of Emergency Medicine (CEM) guidelines. However, there was concern about the availability of middle-grade medical cover. We were informed by the lead A&E consultant and deputy clinical director that this was the main risk on the A&E risk register.
- There was a plan to help alleviate this situation with the use of advanced nurse practitioners who had the specialist skills to work in advanced clinical roles in the Majors and resuscitation areas. However, some of this staff group told us they were concerned that they would be expected to undertake clinical treatments outside of their levels of competency without supervision by experienced middle-grade clinicians, especially at night when consultants were not working in the department. The trust told us they did not have any expectations that these staff would practice unsupervised until they were fully competent.
- The trust risk register stated that there was insufficient staff to run the middle-grade doctor rota seven days a week, 24 hours a day. It reported that this was mitigated by the employment of locum staff and a plan to extend cover by advanced nurse practitioners who work in the majors area until 2am.
- Trust records we reviewed showed there was an establishment for 9.75 whole time equivalent (WTE) consultants. At the time of the inspection, there were three vacant posts, one of which was covered by a locum consultant.
- Consultants would work in the department until 10pm, however there were occasions when they worked until midnight. A middle-grade doctor would then take over. A consultant would remain on call for advice or to come to the department if required. We were told that, although the majority of the middle-grade doctors were locums, they were experienced and, in most cases, had worked in the department for some time.

- The deputy clinical director for medicine, who was also the lead A&E consultant told us they were recruiting three new consultants, posts which would allow them to provide 16-hour 'shop-floor' cover, and meet CEM guidelines.
- The advertisement also sought three staff and associate specialist doctors to work as middle grades, covering the department in the absence of consultants.
- There was an establishment for three specialist registrars who were training to be A&E consultants, although the Deanery was only able to fill one of these posts. There were also two junior doctors who were on core training contracts.
- Between 2pm and 10pm, primary care doctors employed by a private healthcare provider saw and treated patients who attend with minor illnesses, normally treated in a GP's surgery.

Major incident awareness and training

- There was a major incident plan, with sub-plans for Chemical, Biological, Radiological, Nuclear and Explosives (CBRNE) incidents. There was also a lead consultant for major incidents and emergency planning.
- A designated room contained decontamination facilities for use during a CBRNE incident. This room also contained hazardous material suits, breathing apparatus and other equipment.
- The deputy clinical director for medicine told us they had a team which would go out to the scene of a major incident to provide pre-hospital care. This was called a medical emergency response incident team (MERIT).
- The lead consultant for major incidents and emergency planning told us they had gone on a training course for major incident medical management and support in 2014. Although they told us they had not had recent MERIT training, they said that this training had taken place in the past.
- We spoke with qualified nurses, healthcare assistants and emergency department assistants about their roles in a major incident. Although not all were able to describe their duties as detailed on major incident action cards, they all knew where to view these cards on the hospital intranet. This meant there was a risk not all staff would be able to effectively respond to a major incident.
- Staff told us that there had not been any full major incident simulation exercises undertaken in the A&E department in the last year.

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Are urgent and emergency services effective? (for example, treatment is effective)

Requires improvement 

The effectiveness of the service required improvement. We found that some of the guidelines for the treatment of different clinical conditions had not been reviewed for up to seven years. This created a risk of patients not receiving the most up-to-date and effective care.

We found that, although qualified nursing staff could request clinical supervision, there was no regular supervision, except in the case of newly qualified staff.

There was a nurse on each shift dedicated to checking if patients required nutrition and hydration. However, we observed that, at busy times, this nurse got involved in emergencies and did not have time to check if patients needed something to eat or drink.

We found that audits were regularly undertaken to assess the effectiveness of the clinical work of the A&E department.

We found that paediatric A&E nurses undertaking triage assessments had not been signed-off as being competent to do this. Nurses who were only five months post-qualification were triaging adult and paediatric patients without supervision.

There was good multidisciplinary team working in the department.

Evidence-based care and treatment

- We found that the clinical staff followed The National Institute of Health and Care Excellence (NICE) guidelines which were available on the trust's intranet. There were 70 guidelines for adult patients and 43 for children. While most had been reviewed, nine of the adult guidelines had last been reviewed in 2008 or 2009. With regard to the paediatric guidelines 12 of the 43 had last been reviewed in 2008 or 2009. It is important to keep clinical guidelines under review to keep them up-to-date with changes in medical management and safety alerts.

- The A&E risk register reported that the department was not fully compliant with the NICE guidelines for seizure. This was because a first fit (seizure) clinic was not available in the trust. However, the risk register reported that controls were in place, including the provision of safety advice cards to patients.
- There were guidelines for the treatment of different clinical conditions, although some of the guidelines – for example, on the treatment of bronchiolitis (a chest infection that affects babies) – had not been reviewed for seven years.

Pain relief

- On most occasions, we saw that patients were regularly checked to see whether they required pain relief and were given medication in good time. However, when the department was busy, we observed some patients whose pain relief needs had not been regularly checked. We found this was more likely to occur when patients were in the Majors area; in the triage area, patients' pain needs were managed effectively.
- A review of 20 patient records showed that pain scores were only documented in nine cases. Of these, only one set of notes showed a pain re-assessment within one hour.
- We observed nursing staff administering paracetamol and ibuprofen painkillers through patient group directions (PGDs), which are specific written instructions for the supply and administration of medicines to specific groups of patients.
- The department had participated in the CEM's Pain in Children Audit and performance was either about the same or better than other similar trusts.
- The department had undertaken the CEM fractured neck of femur audit in 2012/13. This showed performance in the upper quartile nationally for three of the four re-evaluation of analgesia questions. This meant that the department's performance was better than the national average.

Nutrition and hydration

- Patients in the Majors area had their nutrition and hydration needs regularly checked by designated members of the nursing team. The person responsible for these duties on each shift was identified by a pictogram for easy identification by patients. These changes had followed the A&E patient survey of 2014 which had reported poor availability of food and drink in

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the department. However, we found that, when the department was particularly busy, these checks were not undertaken, mainly because the dedicated nurse was fully occupied with other duties.

Patient outcomes

- A&E medical staff carried out CEM audits. Audits included asthma in 2009/10, vital signs in Majors in 2010/11 and consultant sign-off in 2011/12. In 2012/13 CEM audits were carried out for renal colic, fractured neck of femur, and feverish children. A CEM audit of severe sepsis and septic shock was undertaken in 2013/14.
- Performance in the lower quartile was noted for four questions in the report for severe sepsis and septic shock. Results included 10% of patients being administered antibiotics within one hour, against a national target of 50%. The three other questions concerned capillary blood glucose measurement on arrival, the initiation of high-flow oxygen and obtaining blood glucose.
- In February 2014, the trust audited the management of head injury in A&E. It was recommended that the guidelines be updated, that a poster with the guidelines be displayed in the department, and that teaching sessions be held on head injury management. It was also suggested that there should be adequate levels of nursing and medical staff. We found that actions had been taken: guidelines were displayed in the department, and there had been increases in staffing levels to comply with the draft NICE guidelines on staffing levels in A&E departments. There was also an on-going recruitment process for consultant and middle-grade medical staff.
- An audit under the auspices of the Trauma Audit & Research Network (TARN), a nationally recognised trauma study based in Salford, was carried out in March and August 2014. Its August report concluded there had been a “notable improvement in the probability of survival of TARN patients over the last couple of years”.

Competent staff

- Qualified nursing staff could undertake advanced training to become emergency nurse practitioners working with minor injuries, or advanced nurse practitioners working in the Majors and resuscitation areas.

- Qualified nursing staff told us that clinical and one-to-one supervision was available when they needed it, but it was not available on a regular, organised basis. The exception was for newly qualified nurses new to the department.
- Supervision was readily available for healthcare assistants and emergency department assistants.
- Staff told us that they had regular annual appraisals.
- We reviewed trust records for the last available quarter. In the case of administration and clerical staff, appraisal rates were at 74% for the period July to November 2014. For nursing staff, the figures were 61% for the period April to June 2014 and 17% for the period July to November 2014. These figures indicated a low level of appraisals.
- We spoke with the consultant who had the lead for training in the department. They told us that monthly simulation training scenarios were undertaken in the resuscitation area by medical and nursing staff. They also organised cross-specialty, multidisciplinary paediatric emergency training for all staff in the department.
- Debriefing sessions (following stressful critical incidents or patient deaths) were organised by the lead consultant.
- The simulation and debriefing sessions looked at ‘human factors’ training methods, which examine the interaction between humans and technical systems. This is good practice.
- We found that paediatric A&E nurses undertaking triage assessments had not been signed-off as competent to do this.
- We found that nurses who were only five months post-qualification were triaging adult and paediatric patients without supervision.

Multidisciplinary working

- The A&E team worked effectively with other specialty teams within the trust. We observed specialty teams composed of medical physicians and surgeons working in the department. This included the prompt arrival of an anaesthetic team in the resuscitation area following a cardiac arrest call.
- In another case, we observed liaison with hospital and community professionals. This involved a child who had suffered a limb fracture. The patient was initially assessed by a paediatric A&E nurse while under the

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overall management of an A&E consultant. The paediatric team in the hospital were involved and contact was made with the health visitor service and social services.

- There was easy access to the mental health crisis team who were managed by the local mental health trust.

Seven-day services

- The A&E department offered a seven-day service, with consultant cover in the department for 16 hours a day. There was also on-call consultant cover, including during the eight hours when there was no consultant in the department.
- There was seven-day access to the mental health crisis team, although this was reduced at night as there was only one member of the team available overnight.

Access to information

- We found that clinical staff who needed patient information were able to obtain it through the A&E Symphony electronic patient record and the trust's intranet.
- Clinical and administrative staff were able to access, interrogate and make entries on to the local safeguarding registers for children and adults.

Consent, Mental Capacity Act and deprivation of liberty safeguards

- Clinical staff obtained consent before undertaking procedures. We observed staff explaining the procedure to patients and marking their agreement in the patient record.
- We spoke with clinical staff who showed variable levels of knowledge about the Mental Capacity Act 2005 and its associated deprivation of liberty safeguards. However, the majority of staff showed a working knowledge of the practical application of the Act.
- We received information from the trust that three, full-day training sessions in the Mental Capacity Act and deprivation of liberty safeguards had been delivered. However, no staff from the A&E department had attended. This meant that staff working at the frontline of care delivery might not have a clear understanding of their roles and responsibilities in relation to the Mental Capacity Act.

Are urgent and emergency services caring?

Good



The caring afforded to patients in the department was good.

Staff treated patients in a caring and understanding manner, taking into consideration their social and holistic needs.

Compassionate care

- During our time in the A&E department, we observed staff dealing with patients in a compassionate manner.
- The majority of the 37 patients and 13 relatives we spoke with told us that staff behaved in a compassionate and caring manner towards them.
- This included nine patients and relatives we spoke with in the adult and children's waiting areas. They told us that staff respected their privacy and dignity and treated them in a caring way.

Understanding and involvement of patients and those close to them

- We observed clinical staff explaining to patients their diagnoses and the treatment they required in a manner that was easy to understand.
- Patients and relatives told us that staff were responsive to their needs.

Emotional support

- We observed nursing and medical staff caring for and treating patients in a dignified and caring manner.
- Patients and relatives told us that clinical staff provided them with emotional support.
- One patient explained how staff had spoken to them in a calming way.

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

Requires improvement 

The responsiveness of the A&E department required improvement.

The department had seen an increase in demand for its services from acutely ill patients with complex health needs.

The current facilities meant that children's needs could not be adequately met. Although there was a children's waiting area, it had no direct entrance and could only be accessed through the main waiting area. The area itself was cramped and untidy and clearly not designed for the number of children and their relatives who attended A&E. There was no control on the entrance and people could enter the area without being challenged. This was a potential safeguarding risk to children.

Although there were systems to provide translation support for patients whose first language was not English, similar systems were not available for patients who were profoundly deaf and used sign language. This could lead to a situation where such patients could receive a less effective or less efficient service than others.

Service planning and delivery to meet the needs of local people

- With the local clinical commissioning group (CCG) the trust developed a plan for a new Emergency Centre to be built on the site of the present A&E department and ready for use in 2017. In the meantime a review of the environment was being undertaken alongside a review of the children's assessment unit which may address some of the limitations of space in the emergency department.
- The department had recognised the specific needs of patients with mental health illness. In partnership with the local mental health trust, they were able to provide 24-hour access to a mental health liaison team.

Meeting people's individual needs

- The triage room was small which meant that patients who were using a wheelchair did not have their privacy maintained. The door to the room had to be kept open. This was discriminatory for patients who were disabled and needed the use of a wheelchair.
- An effort had been made to screen off the reception area to improve patient privacy. Patients said that they felt their privacy was protected while booking in from at area.
- On average, 20% of patients who attended the department were under the age of 16.
- The department included two A&E consultants who were also qualified and experienced paediatric emergency medicine consultants and seven paediatric nurses who held registered children's nurse qualification. They provided dedicated cover between 8am and 11.30pm. It was considered that, between 11.30pm and 8am, the care needed decreased and specialist paediatric nurses were not required.
- During the day, there were usually two registered children's nurses on duty, although, on occasions, there was only one. In these situations, cover was provided by nurses working in the adult areas, with the sickest children being cared for by the paediatric nurses.
- We found that newly qualified paediatric nurses would start triaging patients as soon as they started in the department. This differed in the adult area where newly qualified nurses would wait a year before triaging patients.
- Although there was a children's waiting area, it had no direct entrance and could only be accessed through the main waiting area. The area itself was cramped and untidy and clearly not designed for the number of children and their relatives who attended A&E. There was no control on the entrance and people could enter the area without being challenged. This was a potential safeguarding risk to children.
- There was a children's triage room and a treatment room.
- Children who attended with minor illness during the day were examined by a GP.
- We found that children who arrived by ambulance and needed a trolley were placed in the Majors area.
- Children and young people who presented in mental health crisis, who had self-harmed, or who had taken an

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overdose, were admitted to the paediatric ward. From here they were observed until they received a specialist Child and Adolescent Mental Health Services (CAMHS) assessment.

- There was 24-hour access to a mental health service crisis team based at Swallownest Court, located a short distance from the A&E department. This team had the use of a Section 136 suite (a safe place for vulnerable adults in accordance with Section 136 of the Mental Health Act 1983) for people who need to be detained for the safety of themselves and others. However, the lead A&E consultant told us that access to the mental health team at night could be slow because there was only one person on duty.
- A room in the department was used for mental health staff to consult with and assess patients.
- There was a system to highlight patients who were living with dementia. The trust had a dementia lead nurse who could offer support to patients in the department. The department also had a lead for dementia.
- Patients with a history of self-harm or violence to others could be highlighted using the electronic database. This information was shared with all local A&E departments to alert staff when such a patient attended the department. This gave staff time to prepare and call trust security officers or the police if required.
- Translation services were available for people whose first language was not English. Due to the urgent nature of an A&E department, this was normally provided by professional staff over the telephone or by A&E staff if they spoke the same language as the patient.
- We found that sign language interpretation services were not readily available for profoundly deaf patients who used sign language as their main, or only form of communication. Staff told us they would usually write things down or rely on relatives. When a profoundly deaf patient booked in, receptionists would describe the clothes they were wearing so that triage staff could approach them directly.
- We found that a bariatric bed (suitable for people with obesity) was available for patients who required it.

Access and flow

- Access and flow was monitored in the A&E department through the Symphony database. This recorded all

movement of patients within the department from admission until discharge or transfer to a ward. It also recorded both the time a ward bed was requested and when the patient was moved to that bed.

- In quarters three and four of 2014/15, the trust breached the target that at least 95% of patients attending A&E must be seen, treated, admitted or discharged in under four hours. However, the trust did meet the target in quarters one and two of 2014/15
- We reviewed the data for the first two days of our inspection. This showed that, on 23 February 2015, 89% of patients met the four-hour target; while, on 24 February, the figure was 98%.
- In January 2015, performance was at 91%. For quarter three of 2014/15, performance was at 93% in October, 93% in November and 85% in December.
- The trust was aware, and A&E staff told us, that the pressures of an increasing number of seriously ill elderly medical patients attending the department affected their ability to meet the four-hour target. They also said this was exacerbated by a lack of capacity in a department that was designed for 55,000 patients a year but was now seeing more than 74,000. In October 2014, 6,339 patients attended the department.
- To improve the situation, the trust planned to improve capacity by constructing a new Emergency Centre designed to meet current clinical needs. However, this department will not be operational until 2017.
- With regard to ambulance handover times, we found that, in quarter three of 2014/15 there was one delay of over 30 minutes in October, eight delays in November, 43 delays in December (two were for more than an hour) and seven delays in January.
- Patients who arrived by emergency ambulance must have an initial assessment within 15 minutes. For the year to date, the average waiting time was 46 minutes. In December 2014, patients waited up to 60 minutes to be seen.
- Another indicator of increasing attendance and workload in A&E was the number of patients who left A&E before being seen. In October 2014, the rate was 3.41%, in November it was 4.24%, while in December (the month with the highest attendance), it was 5.77% (368 patients). In January 2015 it fell to 2.52%.
- To manage the flow of patients, the trust had systems to allow those with minor illness to be seen during the afternoons by GPs. Patients with minor injuries were

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treated by doctors and emergency nurse practitioners. However, these initiatives, common to most A&E departments, had not improved the trust's compliance with the four-hour target.

- Staff confirmed that they generally received good co-operation from admitting specialist consultants and teams. They told us there were effective escalation procedures in place. We reviewed escalation algorithms and attended site management meetings where the bed state was discussed by clinical and managerial specialists.
- During our inspection, we observed adult patients waiting up to two hours before receiving an initial triage assessment. These waiting times were exacerbated by the poor accommodation available for staff to triage patients.

Learning from complaints and concerns

- Most patients and relatives we spoke with were unaware of the trust's complaints procedure.
- Between October and December 2014, eight complaints concerning the A&E department were received. This was an improvement on the 24 complaints received in the same period in 2013.
- In January 2015, eight complaints were received. These included two relating to staff attitude, one relating to a failure to diagnose and one relating to waiting times.
- Staff were able to describe the complaints process and the actions they should take if a patient made a complaint to them.
- There was evidence of learning from complaints. The matron for unscheduled care explained that a system of intentional rounding (also known as comfort rounds or round-the-clock care) was developed following a patient complaint.
- A system where a designated member of staff checked on patients' nutrition and hydration needs was introduced following poor results in this area of the NHS survey.

Are urgent and emergency services well-led?

Requires improvement



The leadership in the A&E department required improvement.

Staff we spoke with felt they were well-led at departmental and trust level. However, there was little evidence of engagement with staff through team meetings or monthly quality meetings. Although all staff groups were invited to these meetings, nursing staff found it difficult to attend because of the pressure of workload.

The only evident area of innovation and improvement was the creation of the new Emergency Centre which would not happen until 2017. There was a general belief that this would help end the pressures that were difficult to manage in the present A&E department. However, there were risks within the department that required attention.

Vision and strategy for this service

- Most of the staff we spoke with were able to explain the trust's vision, which was to put the patient first. There did not appear to be a vision for the service apart from the development of a new Emergency Centre which was two years away.
- There were plans to develop an Emergency Centre for the trust. There was a belief this would solve the problems in the department. In the meantime there was a sense in the department that nothing could be done about the current challenges they faced in order to mitigate risks.
- However, the senior managers in the trust told us about other things that were being done. The executive team were developing proposals to separate the division of medicine into two separate divisions: one focussed on emergency care and one on integrated medicine. We were told that this would enable the trust's clinical leaders to review emergency care pathways.

Governance, risk management and quality measurement

- The A&E department held monthly quality governance meetings which were open to all staff, although we found that mainly senior staff attended. We reviewed the minutes of a meeting which took place in January 2015. During the meeting there was a 'clinical effectiveness update' where the clinical audit specialist described the audits which were taking place in the department. It was also agreed that an audit of the operation of the PGDs for eye drops was needed and would be organised.

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- A departmental risk register graded risk and reported on actions taken to mitigate or remove the risk. This was incorporated in the trust-wide risk register. Not all of the risks we identified were on the register.
- The department undertook College of Emergency Medicine (CEM) national clinical quality audits.
- Staff told us that the executive team was very visible and that the chief executive would come down to the department to see what was going on and talk with the team.
- Nursing staff told us it was very difficult to attend departmental meetings, especially when the department was busy, such as over the winter months.

Leadership of service

- The A&E department was part of the directorate of medicine which was headed by a triumvirate which consisted of a clinical director, a general manager and a head of nursing. The A&E department was managed by a senior team comprising an A&E consultant and deputy clinical director, a matron and a service manager.

Culture within the service

- Staff from all disciplines worked well together and there did not seem to be an overly hierarchical system of management.
- One thing that all grades of staff were united on was that they had all been working to the extremes of their endurance in order to care and treat patients over the very busy winter period. The deputy clinical director and A&E lead consultant felt this had affected staff morale.
- Staff expressed to us they felt under extreme pressure from working in a busy department that was not suitable for the numbers of patients being seen.


Public and staff engagement

- Nursing staff told us that there were departmental meetings they could attend, but most told us that, because of the increased workload in the department, they were unable to attend these meetings.
- We saw that engagement with the public had taken place between May and June 2014 as part of the planning for the proposed Emergency Centre.

Innovation, improvement and sustainability

- The main areas for innovation, improvement and sustainability were in the plans for the new Emergency Centre for 2017. There was a general belief that this would help end the pressures that were difficult to manage in the present A&E department.
- A large degree of energy had gone into developing this project, and it was accepted by the trust that, given the outdated department design, there was not much that could be changed to improve matters in the meantime.

Medical care (including older people's care)

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

Information about the service

Rotherham Hospital medical care services were managed by the medical directorates. Specialities included: general medicine, haematology, oncology, gastroenterology, respiratory medicine, cardiology, endocrinology, nephrology and stroke, geriatric medicine and rehabilitation.

There were 264 medical inpatient beds plus additional temporary beds on Ward A3 which was the winter pressures ward.

For the period 2013/14 there were 23,015 medical inpatient admissions to Rotherham Hospital.

During our inspection we visited wards A1, A2, A3, A4, A5, A7, B1 (the medical assessment unit), the discharge lounge, and the coronary care unit. We observed staff interacting with patients; this included a short observation framework for inspectors – a structured observation tool to use for patients with dementia or who are unable to communicate enabling inspectors to record interactions and the impact of the interactions over a specific time period.

We spoke with 77 patients/relatives, 83 staff and reviewed the records of 47 patients.

Summary of findings

Overall we judged this service to require improvement.

Staff shortages were evident and planned staffing levels were not being achieved on many wards; this was impacting heavily on staff morale, sickness and retention. The trust recognised this and recruitment, including from overseas, was underway.

Mandatory training levels were poor and there was not a proactive or structured approach to delivering training. There was little awareness or practical application of the Mental Capacity Act 2005 or its associated deprivation of liberty safeguards, and there was a risk that patients may be unlawfully deprived of their liberty.

Wards and equipment were not always clean. Where patients were infectious, or suspected of having an infection, practices and procedures did not always protect against the risk of spreading infection.

Where patients were at risk of tissue breakdown, there was not always equipment available or provided for them. Pressure sores were not always being reported and there had been a change in the way wounds were managed and assessed. Where a specialist team had previously undertaken this role, this had now been delegated to ward staff. This meant that some ward staff were now not confident to manage wound care.

Pressure on beds meant the discharge lounge was being used as an inpatient ward during our visit. This was discussed with the trust, and they told us the lounge

Medical care (including older people's care)

was due to close which it subsequently was. Patient flow through the hospital was affected by bed availability, however, referral -to -treatment times at the trust were being met.

Patients told us that staff were caring, but recognised that they were under pressure due to staff shortages. Patients and visitors told us that staff were “rushed off their feet” but always delivered care in a kindly way with a smile. Staff treated people with dignity and respect and patients told us that staff were “lovely, caring and friendly”.

There were a significant number of mixed-sex breaches, where male and female patients shared the same bed bays. These were commonplace on ward B1 and staff were increasingly tolerating this as acceptable practice, even though rearranging the beds could alleviate this for some patients.

Are medical care services safe?

Requires improvement 

The safety of this service required improvement.

Staff shortages were evident and planned staffing levels were not being achieved on many wards; this was impacting heavily on staff morale, sickness and retention. The trust recognised this and recruitment, including from overseas, was underway.

Pressure on beds meant that the discharge lounge was being used as an inpatient ward during our visit. This was discussed with the trust during our inspection and the discharge lounge was closed to inpatient use.

There were systems to record incidents, but we saw that some reportable incidents were not recorded, so opportunities for learning were lost.

There was insufficient provision and action taken to ensure mandatory training was delivered. Overall there were significant shortfalls in the provision of training so it cannot be demonstrated that staff were suitably skilled and knowledgeable to provide care for patients.

Wards and equipment were not always clean. Where patients were infectious, or suspected of having an infection, practices and procedures did not always protect against the risk of spreading infection.

Incidents

- Between January and December 2014, there were 22 serious incidents reported in the medical directorate.
- An electronic system was used for reporting incidents. Most staff we spoke with, including bank and agency staff, were able to access this system. There were, however, some staff working in the discharge lounge who did not have access to the reporting system.
- Our review of patients' records and staff rotas showed that some reportable incidents, such as pressure ulcers or staff shortages, were not recorded as incidents. We alerted staff to this and rechecked if reports had been retrospectively completed; we found they hadn't. This meant that there was under-reporting of incidents and opportunities to investigate and learn from incidents were being missed.

Medical care (including older people's care)

- A monthly governance newsletter was circulated to staff. This highlighted the top five incidents and risks in the trust.
- The trust investigated every serious incident through a root cause analysis process and an action plan for improvement was identified. Root, cause, analysis investigations were reviewed and signed off by the medical director and chief nurse and were reviewed by the Quality Assurance Committee.
- The systems for learning from incidents varied on each ward. The best practice we saw was on Ward A7 where a newsletter was compiled and circulated to staff with the findings and root cause analyses of incidents. Other wards reported back through team meetings or individually to staff involved in the incident but not to the wider staff group. The inconsistency in practice did not ensure that learning from incidents was effective.
- We saw that side rooms were used for patients who had, or were suspected of having an infection. Signage to alert staff and visitors of the risk of infection was placed on the doors. On many wards, we saw that the doors to these rooms were open, which meant the signage to alert of the possible risk was not immediately evident. Opened doors also increased the spread of infection. We asked to see if there were risk assessments in place for doors to remain open but they were not available.
- We saw there was clear information displayed or provided regarding the use of segregated toilets for the sole use of patients who had infections, but this was not enforced. We saw that toilets meant for sole use being used by patients not considered an infection risk. This increased the risk of the spread of infection.
- Staff reported that there were sufficient supplies of personal protective equipment such as gloves and aprons. Hand gel dispensers were placed at the entrance to wards and around ward areas. Most hand gel dispensers were adequately full, but one day on Ward B1 we found that six were empty.
- We saw many good examples of staff delivering care using best practice but also saw examples where staff action increased the risk of infection. This included one staff member who cleaned a toilet and left without removing their gloves and aprons before entering a clean area.
- Not all parts of the wards were clean. We saw some areas on wards which were dusty, including some equipment. We revisited one area to establish if the piece of equipment had been cleaned: it had not and was found in use at a patient's bedside.
- In 2013/14, there were 29 cases of *Clostridium difficile* (*C. difficile*) infection. This was in line with the national average but was above the trust's target.
- In the last 12 months, there were no methicillin-resistant staphylococcus aureus (MRSA) infections within the medical division.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for local measuring, monitoring and analysing patient harms and 'harm free' care. This focuses on four avoidable harms: pressure ulcers, falls, urinary tract infections in patients with a catheter, and blood clots or venous thromboembolism (VTE)
- Information about the incidence of pressure ulcers, infections and falls with harm was displayed on all the medical wards and units we visited. The information identified number of days since the last pressure ulcer, falls with harm and infection rate.
- There were 24 pressure ulcers reported between July 2013 and July 2014. The data indicated a reduction between March 2014 and July 2014.
- Between July 2013 and July 2014 the reported prevalence of pressure ulcers and catheter and urinary infections was consistently low. The number of falls increased by four in July 2014 following four months where no falls were reported.

Cleanliness, infection control and hygiene

- The trust had a dedicated infection control team that visited the wards on a daily basis and were highly regarded by the staff we spoke with. The infection control team undertook a range of infection control audits on the wards.
- Domestic staff undertook some audits of cleanliness.

Environment and equipment

- Resuscitation equipment was available on all of the wards; records indicated this checked regularly and ready for use on most of the wards. On Fitzwilliam Ward we saw some gaps where it had not been recorded if the equipment had been checked.
- Some areas were in poor decorative repair, with damaged walls and paintwork, particularly wards A4, B1 and the stroke unit. There were exposed areas of plaster

Medical care (including older people's care)

on walls near patients' beds which, due to porousness, would be difficult to clean effectively. The patient-led assessments of the care environment (known as PLACE), identified damage to walls on the stroke unit with a completion date to rectify of September 2014; this had not been met.

- Some wards were not sufficiently clean. Ward B1 had rubbish on the floor and some patients told us they did not think it was clean. On Ward A3 we saw the floors were dirty and there was blood on two sets of curtains.
- Some ward corridors had grab rails to assist people with mobility problems, but some did not. On Ward A3 there was equipment placed along the corridor blocking the only side with grab rails.
- Staff told us that hoist-weighting scales were not available on all wards but they were available on some.
- On wards A3 and A4, we saw oxygen cylinders being stored in rooms without signage on the outside of the door. In the event of a fire, this may place patients and staff at risk.
- The coronary care unit had eight beds that could be used for patients of either gender. On this unit there was only one toilet/shower room available. This meant that, if a patient was taking a shower, other patients had to use commodes, even if there was no clinical reason to do so.
- Ward B1 (the medical assessment unit) had a high use of the cubicles for potentially infectious patients as they had private toilet facilities. This left two toilets for the remaining 30 patients, with toilets being allocated to male or female patients. This meant that patients often had to wait as the number of available toilets were limited.

Medicines

- The trust had increased pharmacy staffing in summer 2014 in response to NHS England's commitment to a seven-day NHS. A clinical pharmacy service was available on all wards from Monday to Friday, with a limited service focused on the admission wards at weekends. The ward pharmacy service was appreciated by nursing staff but capacity did not allow for the regular participation of pharmacy staff in multidisciplinary team meetings or consultant ward rounds.
- A trust audit in September 2014 showed that around half of all inpatients' medicines were not reconciled within 24 hours of admission to the hospital. National Institute for Health and Care Excellence (NICE) guidance recommends that pharmacists are involved in medicines reconciliation as soon as possible after admission. The chief pharmacist explained that medicines reconciliation was on the risk register and that a business case was being prepared for presentation to the finance committee.
- An unknown number of patients left the hospital without collecting the medicines they needed. The trust had not completed a comprehensive audit of the discharge medicines process to identify how improvements could be made. Instead, arrangements had been made for patients to telephone the ward and return to collect their medicines the next day or, where necessary, for the medicines to be delivered by taxi. The trust employed a technical officer to collect unwanted medicines, including 'take-home' medicines, from wards but the number of uncollected prescriptions was not recorded or monitored. We looked in the take-home medicines cupboard on two wards, and both contained uncollected medicines.
- Evidence collated from speaking with pharmacy staff and from the trust's own audits of medicines reconciliation and supply of medicines at discharge, indicated that a lack of pharmacy capacity was a barrier to service improvement.
- We were advised that pharmacist input into the foundation doctor education sessions had stopped with the August 2014 cohort. Similarly, a medicines course provided by the paediatric pharmacist was offered only on an ad-hoc basis due to a "lack of pharmacist time". Also, the trust did not have sufficient specialised critical care pharmacist hours to support safe and effective drug therapy on the critical care unit (Faculty of Intensive Care Medicine Core Standards for Intensive Care Units 2013).
- On two wards we saw that medications were left with patients and staff did not ensure they were taken. (We saw that some patients did take the medicines left with them.) We saw medications that patients had not taken by one bedside and on the floor on Fitzwilliam Ward and on the floor on Ward B1. We alerted staff as this meant that medications were not safely taken by patients and there was also a risk they could be taken by other patients.

Medical care (including older people's care)

- One patient told us that a nurse had offered him the wrong medication and had insisted they have it despite the patient being positive it was not right. The patient had reported this to the next nurse on duty and this was reported as incident.
- Medicines were stored appropriately, including those medicines that required cold storage. Records showed that medicines were stored at the correct temperature and so would be fit for use.
- Wristbands were available to alert staff to patients' allergies and, in most circumstances, these were in place. Although, we spoke with one patient who had allergies which were not included on the wristband.
- Where patients required oxygen this was given. It was not prescribed so nurses used their judgement when determining the rate to administer. This increased the risk of errors being made and the potential for the patient to receive the wrong dosage.
- Staff we spoke with were clear on their safeguarding responsibilities and knew where to seek advice and report concerns.
- The statistical data for safeguarding training was divided by some core services, such as stroke, but also as 'specialist medicine' or 'healthcare for older people'. The statistics showed that many staff across the medical specialisms had not received safeguarding training. The training rates varied significantly from ward to ward. This low level of training on some wards meant that staff might not be suitably skilled or knowledgeable about safeguarding adults.
- Staff told us the trust had circulated leaflets in staff payslips about safeguarding. This did not ensure that staff read or understood the information provided to them.

Records

- Nurses used all-paper patients' records. Most of the medical records were also paper-based but some aspects, such as the dementia screening tool, were electronic.
- We saw confidential waste bins on wards to enable suitable disposal of sensitive and personal documents.
- Most records we saw were securely stored to protect patients' confidentiality, however, we did see occasional unattended records.
- Online information governance training was included as part of the trust's mandatory training programme.
- Some loose forms and records, such as fluid balance charts, did not have patient identity labels on them so it was possible they could be lost and not retained within the right patient record. Staff raised concerns that records were disorganised and were falling apart.
- We were told that there were no audits of care records to assess their quality and standard of completion.
- One nursing record, including parts of the care plan on Ward A3, was not legible; we asked staff if they could read it, but they couldn't.
- The discharge lounge did not have secure notes storage available. We saw patient records being stored on top of a dressings trolley.

Safeguarding

- The trust had policies and procedures in place for safeguarding children and vulnerable adults.

Mandatory training

- Managers and staff told us that poor staffing levels impacted on staff's ability to attend training.
- Statistical data provided by the trust for mandatory training showed that training was not effectively being delivered to staff. Data included that 7.7% of stroke service nurses had completed dementia training, and 53.8% had been trained in safeguarding adults. In the healthcare for older people staff group, there were no medical nursing staff who had received dementia training and less than 6% had received safeguarding adult training. The number recorded for haematology nurses who had completed moving and handling training in the past two years was nil.
- The rates for some types of training were significantly better than others. This included information governance, equality and diversity and conflict resolution.
- Overall there were significant shortfalls in the provision of training so it could not be demonstrated that staff were suitably skilled and knowledgeable to provide care for patients.
- Healthcare assistants told us that e-learning had to be done in their own time as there was not enough study time available. We were told that most were behind on their e-learning.

Assessing and responding to patient risk

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- The trust used a standard monitoring chart and patient at risk (PAR) early warning tool for adult inpatients. We saw that these scores were reviewed regularly and, where the potential for deterioration was indicated, doctors were consulted.
- Risk assessments for patients for pressure ulcers, falls and venous thromboembolism (VTE or blood clots) were being completed and reviewed appropriately. However, we saw some that were not accurately completed or not updated regularly. This meant the rating of risk would not be accurate and insufficient action may be taken.
- A tissue viability protocol was in place to describe when pressure relieving equipment should be provided.
- Where patients had cannulas fitted, there were visual infusion phlebitis care bundles in place. (A care bundle is a small set of evidence-based practices that combine to improve patient outcomes.) Some, but not all, of these were completed fully, which means there was not sufficient assessment for all patients.
- Some risk assessments were updated regularly and were accurately completed. However, some were not updated or were incomplete so risks were not being effectively monitored.
- On Ward A3 we saw that two incidents were recorded where pressure-relieving mattresses were not available for patients when they needed them. We saw one of the patients had been without a pressure-relieving mattress for eight days. We told staff about this and a pressure-relieving mattress was provided. There was an incident on Ward A1 where a patient was not placed on the correct mattress. The lack of suitable equipment, provided in a timely manner, increases the risk of pressure sores developing.
- The poor staffing levels were affecting staff morale. Some wards were better staffed than others and were able to fill shifts more easily, but we heard repeatedly that, even if wards were fully staffed, personnel were frequently deployed to other wards, leaving shortfalls.
- There was a high use of the trust's own bank staff and external agency staff on most wards. Ward A3, the winter pressures ward, was staffed by four personnel seconded from other wards plus agency or bank staff. The agency staff were block-booked to provide some continuity of care.
- Staff recruitment was on-going and some overseas nurses had been appointed and were due to start.
- Some, but not all, staff shortages were reported as incidents. On the data available for 20 January 2015 – 22 February 2015, Ward B1 (medical assessment unit) reported the highest number of staff shortages, with 17 incidents. This was significantly higher than other wards but could possibly be due to better reporting.
- The trust aimed to have at least one substantive nurse in charge on each shift, but this was not always achieved.
- A review of the staffing levels had been completed in December 2014/ January 2015 but this was yet to be ratified. The trust aimed for the majority of medical wards to have a ratio of one registered nurse to every six-and-a-half patients. While recruiting additional nurses the trust aimed to meet the NICE recommended ratio of one nurse to eight patients.
- Nurse staffing levels were monitored and the findings were made publicly available. The findings were routinely reviewed at board level. Records showed that, for many shifts, planned staffing levels were not being achieved.
- Patients consistently told us that staff were busy and stretched but delivered care in a kindly respectful manner.

Nursing staffing

- Staff shortages were prevalent across the majority of wards and safer staffing levels were frequently not met.
- Staffing meetings known as 'huddles' were held four times each day to review staffing levels across the hospital. This often resulted in staff moving to wards with the greatest shortages but this action also left wards where staff were taken from short.

Medical staffing

- The medical staff skills mix had worse than the national average number of registrar/middle-grade doctors (31% compared to 45%). However, the trust had very slightly more than the national average for consultant posts (34% compared to 33%). The hospital also had better than the national average number junior doctor roles (30% compared to 22%).
- The trust's risk register documented that there were insufficient middle-grade doctors to run the

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middle-grade rota 24 hours per day, seven days per week. As a result, locum doctors had been recruited. Advanced nurse practitioners were also being trained and recruited to provide additional cover up to 2am.

- One consultant was on call at weekends from 5pm Friday to 9am Monday. Onsite presence was provided from 6pm to 9pm each day on the medical assessment ward B1.
- The weekend cover for consultants was provided by two consultants who divided the on cover arrangements between them.
- Onsite medical cover was provided by specialist registrars working a two-shift system 9am to 9.30pm and 9pm to 9.30am, seven days per week, with one specialist registrar per shift.
- A full 24-hour shift system was worked by foundation level 1 and 2 doctors. Out of hours there was an electronic request system for ward staff to ask for routine support from doctors, such as checking in a patient. Junior doctors told us they thought this worked well.
- The medical directorate had a gastrointestinal bleed on-call rota, covered by consultant physicians and consultant general surgeons Monday to Friday from 5pm to 9am and at weekends from Friday 5pm to 9am Monday. There was one consultant on call at any given time. Bank holiday cover was provided from 9am to 9am by one consultant.
- At the time of our visit, the discharge lounge was also being used as an inpatient area for 14 patients due to a lack of beds in the hospital. Staff raised concerns with us that specialist consultants did not oversee the care of patients who were on this ward so the clinical director for medicine took responsibility to review them. We raised our concerns with the trust regarding the medical arrangements in place to ensure that patients were reviewed. The trust told us that the discharge lounge was due to close, which it subsequently did.

Major incident awareness and training

- A range of major incident and business continuity plans were available to ensure that the trust could deliver services in emergency situations. These were reviewed annually to ensure they were up to date and the latest plans were dated November 2014.

Are medical care services effective?

Requires improvement



The effectiveness of the service required improvement.

The trust performed well in the heart failure audit but was not rated as well in the stroke and diabetes audit. There were inconsistencies in the actions being taken to address audit findings. There was a monitored and updated action plan for stroke, but for diabetes the ward staff were not aware of the audit, its findings, or any action plan.

Patients' pain was monitored and managed. Patients' nutritional and dietary intake was mostly monitored but there were some gaps in records.

Access to training was adversely affected by the poor staffing level so staff did not always have the skills they required, such as dementia care and Mental Capacity Act training.

Evidence-based care and treatment

- Evidence based risk assessments were used and updated regularly to identify potential risks to patients. Most were accurately completed however some were not updated or were incomplete so risks were not being effectively monitored.
- Staff told us the alcohol detoxification programme followed national guidelines. There was not a specialist ward available and patients could be admitted on any ward for detoxification.
- Staff on the stroke unit were aware of relevant guidance and this policies and procedures were based on this.

Pain relief

- Patients told us that their pain was effectively managed and they were offered the right medication at the right time.
- We observed some medication rounds where patients were asked if they were in pain or required pain relieving medicines.

Nutrition and hydration

- Nutritional screening assessments were available in all patient records.
- Patients generally reported that the quantity of food was sufficient but there were variable reports on the quality, with most patients telling us it was "acceptable".

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- Where patients had identified nutritional needs, staff were alerted to this by the use of a red napkin and red jug being placed on their tray. Most patients had the appropriate coloured jug by their beds.
- Apart from one patient, everyone had drinks at hand on their bedside tables. One patient told us that staff always ensured their glass was full when they removed the water jugs to refill them.
- Protected meal times were used to allow time for patients to eat sufficiently. Where relatives or friends supported people to eat, they were encouraged to continue this.
- One visitor told us they asked staff to encourage their relative to eat, as they tended to forget.
- Most fluid balance charts we saw were well-completed, however, the audits on some wards identified that they were poorly completed at times.

Patient outcomes

- The summary hospital-level mortality indicator (SHMI) and the hospital standardized mortality ratio (HSMR) between August 2013 and July 2014 showed no worse than the national average for the number of deaths.
- The trust held monthly mortality review meetings where all unexpected deaths were reviewed.
- The trust submitted data to the Sentinel Stroke National Audit Programme (SSNAP) which aimed to improve the quality of stroke care by auditing stroke services against evidence-based standards and national and local benchmarks. SSNAP was pioneering a new model of healthcare quality improvement through near-real-time data collection, analysis and reporting on the quality and outcomes of stroke care.
- During October 2013 to March 2014, SSNAP scored the hospital at level D (the lowest score possible is E). The audit identified poor results in multidisciplinary team working and the provision of speech and language therapy.
- An action plan was in to address the findings of the audit. The plan was monitored and updates were recorded. Staff on the stroke unit told us that the availability of beds affected the trust's ability to meet targets for admission to the stroke unit. There were attempts to ring fence beds, but this was not always possible.
- Between July 2014 and January 2015, 10 patients were given stroke thrombolysis, a medical procedure to break

down blood clots in the brain. The average 'door-to-needle' time was one hour 20 minutes, with the shortest time being 50 minutes. The longest time was one hour 57 minutes

- The trust participated in the Myocardial Ischaemia National Audit Project (MINAP) – a national clinical audit of the management of heart health. The trust performed well compared to the England average for nSTEMI (non-ST segment elevation myocardial infarction) indicators in MINAP audits.
- The 2013 National Diabetes Inpatient Audit found that the trust performed better than other trusts in fourteen of the 21 areas assessed. We asked staff about the findings of the audit on Ward A5, the endocrinology ward. Staff said they were not aware of the audit and its findings, or of any actions that were to be taken at ward level to address the shortfalls. We were told that diabetic governance meetings used to happen in the past, but these had not taken place for months.
- The National Lung Cancer Audit 2014 results showed better than the England and Wales average for multidisciplinary team working and percentage of scans undertaken.
- The average length of stay for patients on medical wards was better in all specialities than the national average.
- Staff undertook intentional care rounds (comfort rounds or round-the-clock care) using a formal checklist to check patients for basic care needs such as toileting and hydration. These were mostly completed but we did see some gaps on the records.

Competent staff

- There were seven out of 18 qualified nurses working in the coronary care unit with a coronary care nursing qualification. This meant that the national guidelines to have 50% of qualified nurses were not met.
- The skills mix of staff was not always suitable to meet to patients' needs. Ward A3 was used as a winter pressures ward so staff were employed on a bank nurse basis or deployed from other wards on a short-term basis. The majority of patients on this ward were medical patients who were considered stable and fit for discharge; however, the staff working on the ward could come from a range of specialities, such as surgery and gynaecology. If patients required procedures such as blood transfusions, staff were not suitably skilled and patients had to be moved to other wards where staff were trained.

Medical care (including older people's care)

- Staff we spoke with expressed concern that they did not always have patient handovers and suitable knowledge about patients' medical needs or the medications to care for them safely. They told us these concerns had been raised with the matron.
- There had been a recent reduction in tissue viability support for wards due to staff vacancies. The tissue viability nurse team that previously provided advice and planning care where patients had wounds or pressure areas had been withdrawn. Staff felt that the reduction of this specialist support had resulted in staff feeling deskilled. While new staff training had been introduced, some staff told us they were not confident about pressure area care and wound management. We spoke with staff about one patient's care and reviewed their notes. There were discrepancies about whether the patient had an abscess or pressure sore so it cannot be ascertained if the patient was receiving the right treatment.
- Training data showed that very few staff had been trained in dementia care. Some staff reported receiving 'on the spot' training from the dementia lead. We found a lack of care planning relating to dementia care and little use of the 'This is Me' booklet, so consideration of dementia care was not embedded into practice when caring for patients.

Multidisciplinary working

- We observed multidisciplinary team meetings on a three wards. Most of these were attended by a full range of staff, including medical staff, nurses, therapists and social workers.
- Expected discharge dates were discussed at the meetings and all decisions were agreed by the multidisciplinary team members. The meeting was used to identify the type of assessments and therapy the patient needed and steps were agreed to arrange this.
- There were some hospital-based social workers who attended meetings. However, ward staff wanting to access community social worker support had to complete referral forms to local teams.
- Patients we spoke with confirmed that they had received assessments and treatments from physiotherapists, occupational therapist and speech and language therapists.
- All ward areas had regular 'huddles' (brief update meetings between staff) where they discussed patients'

- needs and work allocations. Most of these were positively regarded by staff as being useful but high use of agency staff and staff being moved between wards was said to affect the usefulness of the meetings.
- Staff told us that, to refer a patient for occupational therapy, physiotherapy or social work input, an online form had to be completed. Staff told us this was a time-consuming process. We were also told that a verbal referral system was in place, so the referral process was inconsistent.

Seven-day services

- There was a consultant medical rota seven days a week to ensure that there was seven-day medical cover.
- Some telehealth services were used – for example, scans reviewed online to determine if stroke patients were suitable for thrombolysis.
- Staff told us that there could be difficulties accessing equipment on weekends as decontamination staff only worked weekdays. We saw examples where equipment wasn't available when it was needed. Staff confirmed to us that it could take up to two days to get equipment.
- Limited physiotherapy cover was available at weekends and staff told us that priority was given to patients who had medical chest conditions.
- Foundation level 1 doctors told us that, at weekends, there were no phlebotomy services available on Fitzwilliam Ward or the stroke unit. They said this affected their shifts which were already very busy.

Access to information

- Discharge letters to GPs were generated using an electronic system but were sent by mail. Patients were mostly provided with copies. Discharge summaries included the medication prescription. These had to be printed out and taken to the pharmacy as a system was not in place to send them electronically.

Consent, Mental Capacity Act and deprivation of liberty safeguards

- There was inconsistent application of the Mental Capacity Act 2005 across the wards we visited. Staff training rates were low and staff did not display a robust knowledge of the Act.
- On Fitzwilliam Ward, a two-stage assessment tool was used with all patients to establish if they had the capacity to consent. As one of the principles of the Mental Capacity Act is that a person is presumed to have

Medical care (including older people's care)

capacity (unless it is suspected otherwise), this practice goes against the principle of the Act. Staff told us the two-stage assessment was completed to establish if a deprivation of liberty safeguard was needed.

- Staff we spoke with on other wards were not conversant with the two-stage assessment to be completed where it was considered a patient may lack capacity and did not know that an assessment form was available.
- Some records we saw included assessments determining that patients lacked capacity, but these were general risk assessments and not decision specific and we did not see any documented best interest decisions or action plan records as described in the trust's policy. It was therefore not clear what decisions the patients lacked the capacity to make.
- Staff told us that some patients were subject to deprivation of liberty safeguards. We saw referrals in files but staff were not able to tell us what happened to the referral forms. Staff considered that some patients were subject to deprivations when it was not clear from the records if external assessments and authorisations had been completed. This meant that patients may unlawfully be deprived of their liberty.

Are medical care services caring?

Good



Overall, we judged that the caring within the medical service was good.

Patients told us that staff were caring but it was recognised that they were under pressure due to staff shortages. Patients and visitors told us staff were “rushed off their feet” but always delivered care in a kindly way with a smile.

Staff treated people with dignity and respect and patients told us that staff were “lovely, caring and friendly”. There was a significant number of mixed-sex breaches where male and female patients shared the same bed bays. These were commonplace on ward B1 and staff were increasingly tolerating this as acceptable practice, even though rearranging the beds could alleviate this for some patients.

Compassionate care

- The trust used the NHS Friends and Family Test to record and report on patient feedback. This survey asked patients whether they would recommend the

NHS service they received to friends and family who needed similar treatment or care. The average test response rate for the trust was 23%, which was worse than the England average of 30%. The average response rates for medical wards varied from 17% to 37% (from April 2013 to July 2014).

- Patients recognised that wards were understaffed and staff were under pressure. Despite this, we received many comments on how hard-working staff were and that nothing was too much trouble for them.
- Patients told us that their privacy and dignity were protected and staff treated them with respect.
- Most interactions with patients were positive, with staff knowing patients' names and speaking in a respectful manner. Patients were offered choices of food.

Understanding and involvement of patients and those close to them

- Most patients we spoke with told us that they were aware of the discharge plan in place.
- One relative told us that “communication was poor” and “different people tell you different things”. Another relative told us “I do get updated by the doctors, but I have to ask”. Two more relatives said they would like to be “updated more regularly on medical conditions and future plans”.
- With patients' consent, relatives were allocated passwords to allow them to telephone the ward to get updates. This arrangement ensured that confidential information was passed only to relatives and friends who knew the password.
- There were varying responses from patients when we asked if they were involved in their care plans and discharge arrangements. Some were clear that they had been consulted, but some were not.

Emotional support

- On some wards, we saw named nurses identified for patients. Some patients were aware of the named nurse allocated to them but others were not.
- The hospital chaplains visited the wards on a regular basis. A multi-faith room was available in the hospital for patients or relatives to access.
- One patient told us, “When I get upset and cry, they hold my hand and give me a big hug. This always cheers me up”. Another visitor whose relative was living with dementia told us that, “staff seem to understand how to keep him calm and content”.

Medical care (including older people's care)

- On the stroke unit, there was some limited psychology support available. Patients accessed this on a referral basis as the time was limited to one session each week.

Are medical care services responsive?

Inadequate



The responsiveness of this service was inadequate.

Over the previous three months (November 2014 to January 2015) there had been mixed-sex breaches in the medical directorate (where male and female patients shared the same bed bay). There were 44 breaches on Ward B1 (medical assessment unit) and 13 in the clinical decision unit. Staff seemed accepting of mixed-sex breaches and we saw one example where a rearrangement of beds would have alleviated the breach. The occurrence was so commonplace that there was a rubber stamp which staff used to record the breach in patients' notes and tick that an apology was given.

Patient flow through the hospital was affected by bed availability, however, referral-to-treatment times at the trust were being met.

There was little knowledge or evidence of dementia care planning in patients' records. Dementia screening was undertaken but, in practice, this had little effect on improving care for patients. Few staff were trained in dementia.

There were systems to handle complaints but most patients did not have access to information on how to make a complaint.

Access and flow

- The average bed occupancy for the hospital was 89.24%. This was above the England average of 87.5% and the 85% level at which it is generally accepted that bed occupancy can start to adversely affect patient care.
- Bed meetings were held four times daily where a designated staff member took responsibility for staffing arrangements and access to beds.
- The hospital's patient discharge lounge operated from 8am to 8pm Monday to Friday and at weekend 8.00am -

4pm. If a patient was medically and clinically discharged from a ward, they could transfer to the discharge lounge while awaiting final arrangements to be made, such as transport or medication to take home.

- The trust was meeting its operational standard across all medical departments for referral-to-treatment times. This meant that the majority of patients were waiting a maximum of 18 weeks between being referred and seen for treatment.
- Prior to discharge, patients' needs were assessed so that the correct level of care could be put in place at home or a care setting. Home visits were completed and equipment was arranged prior to patients going home. Staff reported that home equipment was accessible.
- Delayed discharges were monitored and, in January 2015, the medical directorate calculated this as being 1.8% of all medical admissions. This was a reduction from the previous month where the figure was 2.09%.
- Discharge letters to GPs were generated using an electronic system but were sent by mail. Patients were mostly provided with copies. Discharge summaries included the medication prescription. These had to be printed out and taken to the pharmacy as a system was not in place to send them electronically.
- We reviewed a sample of discharge summaries. Some contained inconsistencies and some had key information recorded out of place at the end of the summary.
- At the time of our visit, there were medical outliers across the hospital. Outliers are patients under the care of medical consultants but placed on other wards due to a shortage of bed space.
- Due to demand for beds in some specialisms, patients sometimes had to move wards. Between April and November 2014, 13% of patients moved wards three times and 7% of patients moved four times during their admissions. Some of these moves may be due to clinical need, but from data available the extent of this could not be established.
- On Ward B1 (medical assessment unit) staff told us that patients sometimes stayed in the unit for longer than expected as beds on other wards were not available. This affected the availability of beds for newly admitted patients. The longest reported stays for patients was for those requiring side rooms and respiratory beds.

Medical care (including older people's care)

- The risk of readmission for elective hospital admissions was higher than the national average, particularly for clinical haematology, respiratory conditions and general medicine.
- On Ward A1, a decision was taken to close some beds when it was recognised that staffing levels did not allow safe care to be delivered. New leadership staff had been brought on to this ward.

Meeting people's individual needs

- Over the previous three months (November 2014 to January 2015) there had been mixed-sex breaches in the medical directorate (where male and female patients shared the same bed bay). There were 44 breaches on Ward B1 (medical assessment unit) and 13 in the clinical decision unit. The trust did record the duration of the breaches. Staff seemed accepting of mixed-sex breaches and we saw one example where a rearrangement of beds would have alleviated the breach. The occurrence was so commonplace that there was a rubber stamp which staff used to record the breach in patients' notes and tick that an apology was given. We raised this with the senior leadership team during our inspection and they took immediate action to address this. Information we received from the trust following our inspection showed this rate had significantly reduced.
- We saw that medical staff completed a dementia screening tool for patients over the age of 65. We saw some of these in paper format, and others were electronic; there was not a consistent approach throughout the hospital. Where the screening tool identified the possibility of dementia, this information was included in the patient's GP discharge letter.
- On Fitzwilliam Ward, staff told us there were often many patients who were living with dementia. A 'This is Me' booklet was available for relatives to complete to provide information about patients' lives and preferences. We asked to see completed copies but none were in use, even though there were patients on the ward who were living with dementia.
- Where patients were living with dementia, a 'forget-me-not' sticker was placed on their wristband to alert staff. Staff also wore the stickers on their name badges to identify them as 'Dementia Friends', an initiative promoted by the Alzheimer's Society which promotes understanding and support for people living with dementia.

- The care records for patients living with dementia did not contain care plans which described to staff how best to meet the person's needs. There was a lack of detail about the person and their preferences to evidence that their dementia needs were considered or met.
- There was a telephone interpretation service available for patients and their families who did not have English as their first language. Some staff said they also used picture boards to facilitate communication.
- Smoking cessation patches were available to support patients to manage cravings in hospital or to give up smoking.
- There was a 72 hour post discharge check made on patients who were discharged from the stroke unit. This could be a face-to-face visit or a telephone call.
- On wards we saw a range of displays with information for patients. These were usually relevant to the type of ward and included dementia care and nutrition. Leaflets were available on specific medical conditions for example, strokes.

Learning from complaints and concerns

- During 2014, the highest number of complaints were made in the medical directorate, accounting for 26% of all complaints received.
- Most patients we spoke with did not always know about the complaints procedure or how to raise concerns. One relative told us about their concerns but hadn't formally complained as they did not have the confidence that it would not affect the care of their relative while they were still in hospital. They said they would complain after their relative was discharged.
- All staff we spoke with told us that they tried to resolve patient concerns at the earliest opportunity.
- Information leaflets were available in English but no other formats or languages.
- We saw some evidence of learning from complaints, with reviews of care being discussed with staff.

Are medical care services well-led?

Requires improvement 

The leadership in this service required improvement.

Medical care (including older people's care)

Staff were under pressure at all levels of the trust, mainly due to poor staffing levels. This was affecting staff morale. Managers knew about risks and areas of concern but plans to address and improve the services offered were not robust.

There was some confidence that immediate line managers would listen and support staff. The Trust Board were visible, but staff described them as being "remote from the day-to-day pressures" they faced.

Vision and strategy for this service

- The trust had a set of core values. Some, but not all staff, knew these.
- The medical directorate had a vision of how they wished the service to develop. It was evident though that the suitable staffing and grass-roots change required immediate work before ambitious plans could be progressed.

Governance, risk management and quality measurement

- The failure to meet staffing levels across the medical directorate was included on the trust's risk register. Recruitment was on-going and there was an increased use of block-booked agency staff. However, the measures taken were not always ensuring that suitable staffing levels were met.
- Serious incidents and investigations were reviewed at board level, ensuring that there was 'floor-to-board' awareness.
- Directorate of medicine risk and governance meetings were held monthly.
- Clinical supervision of staff was not taking place. This was confirmed by all staff we spoke with. On Ward A4, staff told us there were some group debriefings and reflection time for staff, but this was not seen on other wards.
- We found a range of gaps in care records and audits were not in place to monitor and address this.

Leadership of service

- All wards held monthly staff meetings which were used to discuss a varied range of topics for each ward.
- Staff shortages meant that ward managers were sometimes included in the staffing numbers for the wards. This meant that time for managerial roles and tasks was reduced. On one ward, we saw that incidents

which required review had not been checked for eight days. We saw that actions hadn't been taken for one incident, and one patient who was assessed as requiring a pressure-relieving mattress was not provided with one for eight days.

- Ward A1 had recently had a change of management after it was identified that the ward was not being managed effectively and there had been increased falls, medication errors and complaints. Over a short period of time the new managers had made improvements and it was reported that staff morale and sickness absence levels had improved.
- Two members of staff told us they didn't feel able to report concerns.

Culture within the service

- Ward staff were under pressure due to staff shortages and morale was low. This reflects the findings of the staff survey. Some staff were tearful when speaking with us about the pressures they were under. Some staff told us they were looking for other jobs and some were leaving without jobs to go to.
- At ward level, staff told us they always did their best for patients and worked as a team.
- Staff told us their immediate managers were accessible and approachable but, above this level, staff regarded the management as remote and not recognising the pressures they were under.

Public and staff engagement

- The NHS Staff Survey 2013 for the trust compares with other acute trusts on an overall indicator of staff engagement. Possible scores ranged from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's score of 3.54 was in the lowest (worst) 20% when compared with trusts of a similar type.
- Internal staff surveys were conducted and the full staff survey results were due towards the end of January/early February 2015; 34% of staff in the medical directorate responded to the survey. A regularly updated and directorate-specific action plan was available to address the findings from the survey.
- The trust was taking some measures to improve engagement with staff. One initiative was a Listening into Action forum where managers met with staff. Some staff were aware of this, but others were not.







Medical care (including older people's care)

- The sickness absence rates for the trust were consistently higher than the national average since January 2012. The risk register showed that, at February 2015, the rate exceeded 6%.
- Some staff told us about a new sickness policy that had been introduced, designed to reduce sickness rates. We were told that support from occupational health was available where staff were experiencing stress.
- There was a significantly high nurse vacancy rate on most wards. Ward A7 appeared to have the fewest vacancies. The wards with the highest vacancy rates were Ward A4 (39%), Ward A2 (36%), Ward B1 (22%), Ward A1 (16%) and Ward A5 (14%).
- The trust told us that exit interviews were conducted but we spoke with staff who were due to leave within days and they had not been offered an exit interview.

Innovation, improvement and sustainability

- Our interviews with managerial staff showed that they were aware of the risks and challenges in the medical directorate.
- The head of nursing told us that work was underway to develop the matrons' role and improve leadership in the medical directorate. This involved introducing key performance indicators and project allocations.
- On the stroke unit, there was a training and development programme for band 5 nurses to develop skills in thrombolysis.
- The trust had one of only five photopheresis services in England. Extracorporeal photopheresis involves treating blood using ultraviolet light and is used to reduce the risk of rejection where patients have had bone marrow transplants.

Surgery

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

Information about the service

The surgical services directorate consisted of anaesthetics, critical care, ear nose and throat (ENT) services, endoscopy, general surgery, maxillofacial surgery, the operating theatres, ophthalmology, orthopaedics, podiatry, rheumatology, and urology. There were 139 surgical inpatient beds across five ward areas. There were 11 theatres including a dedicated emergency theatre, and two day surgery theatres.

We visited pre-assessment, the day surgery units, operating theatres and the recovery unit. All surgical wards were visited, including the surgical assessment unit (SAU), general surgery (wards B4, B5), surgical patients on the gynaecology ward (Ward B11), urology (Sitwell Ward) and trauma/orthopaedics (Keppel Ward and Ward B3).

We spoke with 15 patients and 60 members of staff, including matrons, ward managers, nursing staff (qualified and unqualified), medical staff (senior and junior grades) and managers. We observed care and treatment and looked at care records for 10 people. We received comments from people who contacted us to tell us about their experiences. Before the inspection, we reviewed performance information about the trust.

Summary of findings

Overall, we rated surgical care as 'requiring improvement' for being safe and responsive. The surgical care was rated 'good' for being caring, effective and well-led.

The directorate was responsive to patients' individual needs, but there were concerns over waiting times, such as the 18-week referral to treatment time target within trauma and orthopaedics, the high number of medical outliers on surgical wards, access and flow for patients attending the fracture clinic and mixed sex accommodation breaches on the SAU.

Never Events are serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken. There had been one Never Event in surgery in the last 12 months (January to December 2014) relating to a retained surgical pack. However, the 'five steps to safer surgery' procedures included in the World Health Organization (WHO) surgical safety checklist were not completely embedded in theatres.

There were mechanisms in place to manage incidents and monitor some of the safety aspects of wards, such as specific patient harms. However some staff were not confident in their explanations of the reporting mechanisms. Most staff received feedback following incidents.

Surgery

Nurse staffing levels were not always maintained as planned. However, the arrangements in place ensured that sufficient numbers of skilled and knowledgeable staff were on duty to safely meet the needs of patients. The trust was actively recruiting nurses to fill vacancies.

The care and treatment of patients followed evidence-based best practice and professional standards. Surgical outcomes were generally good and were monitored.

Most patients we spoke with were positive about the care they received from staff. Patients felt their dignity and privacy were respected and described staff as 'kind and caring'. Patients' nutrition, hydration and pain relief needs were met appropriately.

The current senior leadership team had a good understanding about their roles within the directorate and were aware of the risks and developments required to improve patient care. A number of developments were being implemented, however, it was too early to say whether these would be effective and sustainable.

The directorate had governance structures in place and took part in clinical audit and clinical effectiveness programmes to try to improve the quality of care delivered by the hospital. However, governance frameworks were not yet fully embedded and work was on-going to ensure that processes were robust. Patient and staff engagement was improving.

Are surgery services safe?

Requires improvement 

Safety required improvement.

There were mechanisms in place to manage incidents and monitor some of the safety aspects of wards, such as specific patient harms. However some staff were not confident in their explanations of the reporting mechanisms. Most staff received feedback following incidents.

Surgical areas had vacancies within the nursing department teams; however, the arrangements in place ensured sufficient numbers of skilled and knowledgeable staff were on duty to safely meet the needs of patients. The trust was actively recruiting to fill vacancies.

Clinical staff used various means of assessing and reviewing the needs of their patients to ensure they received safe interventions. Records were completed accurately for each stage of treatment.

The medical team were responsive in times of emergency and staff had access to consultant-led care for advice and guidance.

There had been one Never Event in surgery, which related to a retained swab. However, the 'five steps to safer surgery' procedures (included in the WHO surgical safety checklist) were not completely embedded in theatres.

There were arrangements in place for the effective prevention and control of infection and the management of medicines. Equipment was checked in line with professional guidance.

Incidents

- Staff reported incidents, near misses and errors. However some staff were not confident in their explanations of the reporting mechanisms. Most staff received feedback following incidents.
- The trust reported a similar number of incidents compared to the England average.
- Ten serious incidents were reported in surgery between January and December 2014. The themes related to pressure care, delayed diagnosis and management of falls. Following a review of these incidents,

Surgery

improvements in the timely completion of patient assessments, information given to patients prior to discharge and staff training had been identified and implemented.

- There was one Never Event in surgery in 2013/14. A root cause analysis had been undertaken and an action plan developed. As a result of the incident, assurance was being sought through the clinical audit and effectiveness programme on completion of the WHO surgical safety checklist.
- The hospital mortality review policy was in place. Trust-wide standardised, evidence-based reporting and investigations ensured that all unexpected deaths were reviewed by the mortality steering group.

Safety thermometer

- The trust used the NHS Safety Thermometer which is a local implementation tool for measuring, monitoring and analysing harm to patients and harm free care. Monthly data was collected on pressure ulcers, falls, urinary tract infections for people with catheters, and venous thromboembolism (VTE or blood clots).
- Nursing staff did weekly audits on harm-free care, patient experience and the environment.
- Fifteen pressure ulcers were reported between July 2013 and July 2014. The prevalence rates had reduced for March to July 2014. Seven falls were reported across the date range, with none reported between May and July 2014. There were 14 urinary tract infections for people with catheters reported, with the prevalence fluctuating across the period.
- Trust data showed that 98.5% of all adult general surgery inpatients had received a VTE risk assessment on admission, against a trust target of 95%
- The general surgery dashboard showed that harm free care was better than the trust target of 95% for the period April to October 2014.
- Safety Thermometer information was displayed in clinical areas.

Cleanliness, infection control and hygiene

- Ward areas appeared to be clean and we saw that staff regularly washed their hands between patient appointments and interventions. Staff were 'bare below the elbows' in line with trust policy and national guidelines for best hygiene practice.

- There were no methicillin-resistant staphylococcus aureus (MRSA) infections within surgery over the last 12 months. There had been two reported cases of Clostridium difficile (C. difficile) for general surgery between July and September 2014.
- Elective patients undergoing orthopaedic surgery were screened at pre-assessment for MRSA and patients were isolated in accordance with infection control policies.
- There was a dedicated team of domestic staff for theatres. All theatre areas appeared clean and tidy, however, the walls were in need of decorating. The estates department began this work during the inspection.
- We observed staff in all surgical areas following guidance for the safe disposal of different types of clinical and domestic waste and used needles (sharps)
- The unit participated in ongoing surgical site infection audits run by Public Health England. The last published results for April 2013 to March 2014 showed that there were no surgical site infections for the trust relating to hip replacements.
- Infection control information was visible in all ward areas, with each ward having an infection prevention and control information board. This information included how many days a ward had been free from C. difficile.
- The directorate used the Infection Control Nurses Association audit tools for monitoring infection control standards. Infection control audits demonstrated that most areas within surgery were compliant with infection, prevention and control standards.

Environment and equipment

- Ward-based staff reported having sufficient equipment to enable them to carry out their duties. Replacement items or new equipment could be obtained if required, with relative ease.
- There were effective systems to ensure that resuscitation equipment, including emergency drugs, were readily available in all surgical areas, including theatres. There was a dedicated team of operating department practitioners responsible for routinely checking all resuscitation trolleys in preparation for use. Records showed that checks were completed each day.

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- Theatre staff understood their responsibilities for preparing and handling surgical instrumentation at all stages of the operative procedure.
- Technical equipment used for monitoring patients had been safety tested and stickers indicated the next date for checks to be made.
- Full tracking and traceability of surgical instrumentation was provided which offered a full audit trail ensuring that each decontamination process was followed correctly and according to international standards. There was a four-hour turnaround time for theatre trays.
- Theatres had three supplies coordinators who dealt with all stock ordering and loan equipment. Stock rooms were clean, tidy and well-labelled.
- Endoscopes were stored in a monitored storage drying cabinet. The service was in the process of buying a vacuum sealer for storage of scopes.
- There was equipment available on wards and within theatres for patients with a high body mass index (BMI).
- Theatres had two x-ray machines. Staff told us that sometimes the operating lists had to change to accommodate the use of machines however, they were able to obtain a third x-ray machine in an emergency.

Medicines

- Storage arrangements were seen to be in place for the different types of medicines, including items which required refrigeration. We saw temperature checks had been carried out on fridges, ensuring correct, safe storage. Suitable disposal arrangements were in place for medicines that had expired or were no longer required.
- We saw that the the preparation and administration of controlled drugs was subject to a second independent check. After administration, the stock balance of an individual preparation was confirmed to be correct and the balance recorded.
- Theatres had a main pharmacy supply cupboard which was checked and stocked by a pharmacist each week.
- Wards had a small supply of simple medicines, such as pain relief, which could be given out subject to appropriate checks out of hours. There was also access to the on-call pharmacist for items that were not available in ward stock cupboards. The on-call pharmacist could dispense items remotely where required.

- Patients waiting to be discharged told us they hadn't waited long for their take-home drugs and had received sufficient information from staff about their medicines.

Records

- Care pathways were in use for patients undergoing elective surgery. The pathway incorporated the patient journey from pre-assessment, admission, surgery, recovery and discharge. Records we looked at were completed accurately.
- Surgical wards completed appropriate risk assessments. These included risk assessments for falls, pressure ulcers and malnutrition.
- There was a comprehensive pre-operative health screening questionnaire and assessment pathway.
- Dementia screening tools were in place and completed for patients over the age of 65. Records showed that, where a diagnosis of dementia was made, patients received further investigations and were referred to the memory clinic.
- Regular audits of documentation were evident across a number of surgical specialties. An action plan had resulted in improvements to the countersigning of deletions, alterations and author designations.

Safeguarding

- There were safeguarding policies and guidelines for the protection of vulnerable adults and children. The trust had a designated safeguarding lead who provided advice and training for staff and linked to the multi-agency safeguarding networks.
- Nursing and medical staff were knowledgeable about what actions they would take if they had any safeguarding concerns, and had an awareness of the hospital safeguarding systems and processes.

Mandatory training

- There was a programme of mandatory and statutory training which included fire safety, information governance, equality and diversity, infection control and advanced life support.
- Theatres had a dedicated training co-ordinator. There was a display of all staff's mandatory training figures in theatres which showed good compliance for most areas.

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- Mandatory and statutory training compliance formed part of the performance and development review where 100% training compliance was required. Trust data showed 65% of staff at the trust having completed training.
- Records showed that staff had received training in resuscitation including advanced life support in line with the Resuscitation Council guidelines 2010.

Assessing and responding to patient risk

- The trust used a standard monitoring chart and patient at risk (PAR) early warning tool for adult inpatients. The standard monitoring charts recorded observations a minimum of every 12 hours unless a decision had been made at a senior level to increase or decrease the frequency of observations for the patient.
- The PAR was a daily chart which included fluid balance and was used to closely monitor the patient. Patients on the PAR chart were monitored at least four hourly unless a documented decision was made to decrease this frequency. An early warning scoring tool was used on both charts. The calculation of a total score initiated a course of action for example, increased frequency of observations and referral to an experienced doctor or the critical care outreach team.
- Escalation processes were in place to obtain a medical review or response within 30 minutes. Staff confirmed that there was good access to the patient's consultant or consultant on-call out of hours when urgent medical input was required.
- The five steps to safer surgery (part of the WHO surgical safety checklist) was not being consistently completed across all surgical areas. For example, an audit of the surgical checklist (July 2014) showed that of the 51 checklists audited, only 14% of all three parts were completed. The service had identified this as a risk. A task and finish group had been set up to facilitate the checklist and take action on issues preventing full engagement of all staff in theatre by March 2015. The length of time between the initial audit and the completion of the task and finish group work was some eight months. This meant there was no urgency to monitor improvements in this important safety area.
- We observed one theatre team undertaking the 'five steps to safer surgery' procedures. All processes from the sign-in before induction of anaesthesia to the sign-out when the patient left theatre were completed correctly.

- Protocols were in place for surgical site marking. All checklists were completed before the patient was transferred to theatres.
- Morning 'huddle' meetings were used to identify and decide priorities for emergency surgery, taking into account obstetric cases and major trauma.
- Surgical staff used a sepsis screening tool as part of the assessment under the early warning score. This enabled them to alert medical staff to patients with clinical indicators of possible infection.

Nursing staffing

- The directorate had a number of nursing vacancies while facing demand for an increase in-patient capacity. For example, the orthopaedic ward (Ward B3) had 6.65 whole-time equivalent (WTE) nurse vacancies and surgery (Ward B4) had 4.27 vacancies.
- January 2015 trust data showed there were two (0.3%) shifts that had not been staffed as planned in the surgical directorate.
- There was a safe staffing and escalation protocol to follow if staffing levels on a shift fell below the agreed number. Work had been done by the trust to reassess staffing levels on wards and the trust was in the process of increasing staffing, including recruiting from abroad. Recruitment had commenced and planned to continue throughout January and February 2015. This was to ensure that staffing establishments reflected the acuity and dependency of patients.
- Staff reported good cross department working to support patient care. Bank (overtime) and agency staff were used to fill any deficits in nursing staff numbers. Staff could also work extra hours.
- Data for January 2015 showed that the directorate filled 81 shifts with agency nurses (12.8%) and 99 nurse bank shifts (15.7%).
- The planned and actual staffing levels were displayed on noticeboards on each ward. On the days we inspected the wards, there were no shortfalls in planned staffing levels.
- Nursing handovers took place at the beginning of each shift change and a mid-morning handover after the medical ward rounds. Medical staff were also encouraged to join these handovers as part of the team.
- There were shortfalls in staffing levels identified in the fracture clinic. A business case had been submitted to increase the current establishment to include three

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additional plaster technicians. At present the service was managing with staff covering additional shifts, however, staff told us they regularly stayed over their contracted hours to manage patient care.

- There was a system for planning theatre activity to allocate staff efficiently and to respond safely and flexibly to changes in routine. Close cooperation by the theatre manager with surgeons and anaesthetists was observed.

Medical staffing

- Surgical services were overseen and led by consultants for each 24-hour period.
- Arrangements were in place to ensure that the surgical directorate had access to the support of consultant surgeons and anaesthetists during normal hours and out of hours, with on-call access if needed.
- The SAU was staffed by doctors of appropriate grades who were free from other clinical commitments. Consultant presence on the SAU had increased, providing one to two hourly visits rather than an evening ward round.
- The trust used the Situation, Background, Assessment, Recommendations (SBAR tool) to ensure that all information was handed over.
- Handovers occurred each morning at 8am. The night on-call team prepared the list of patients for handover. This was available on the trust's intranet and included patient details, main condition, investigations, provisional diagnosis and management. A copy of the handover was kept for future reference.
- The directorate was expanding nursing roles and had advanced nurse practitioners in post and in training.
- Rotas for general surgery were covered by 8.5 WTE posts, including two associate specialists, 2.5 trainees, three middle grades and one locum. All medical tiers were, therefore, adequately covered.
- Medical staff shift lengths were in line with the European Working Time Directive. The General Medical Council National Training Survey 2014 identified no risks with regards to doctor workloads.

Major incident awareness and training

- The trust's major incident plan provided guidance on actions to be undertaken by departments and staff who

may be called on to provide an emergency response, additional service or special assistance to meet the demands of a major incident or emergency. Staff were familiar with their role in an emergency response.

- The trust was part of the Yorkshire and Humber trauma network. Major trauma would normally bypass the hospital to a trauma centre, however, when trauma cases arrived in A&E a trauma call would alert the general surgeons, orthopaedic surgeons and anaesthetist to be present and on standby in A&E.
- Staff told us they participated in training for emergency scenarios such as fire evacuation, loss of vital services and responding to a cardiac arrest.

Are surgery services effective?

Good



Surgical services were effective.

Processes were in place for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs.

Surgical outcomes for patients were monitored and results contributed to a range of external comparative reports. Mortality indicators were within expected ranges. The emergency surgery theatres followed guidance in line with the National Confidential Enquiry into Patient Outcome and Death (NCEPOD).

There was effective communication and collaboration between multidisciplinary teams, which met regularly to identify patients requiring visits or to discuss any changes to patient care.

Patients were able to access suitable nutrition, hydration and pain management. Clinical staff had a range of suitable skills, assessed through competency checks, which enabled them to undertake their duties effectively.

Evidence-based care and treatment

- Surgical specialties managed the treatment and care of patients in accordance with a range of guidance from the National Institute for Health and Care Excellence (NICE) and Royal College of Surgeons. This included guidance for acutely ill patients in hospital.

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- The directorate took part in all the national clinical audits they were eligible for, and had a formal clinical audit programme where national guidance was audited and local priorities for audit were identified.
- The emergency surgery theatre followed guidance in line with NCEPOD.
- Patients followed an enhanced recovery programme for hip and knee replacement surgery. This was an evidenced-based approach which allowed patients to play an active role in their care, helped them to recover more quickly following major surgery and return to a normal life as soon as possible.
- The endoscopy unit received Joint Advisory Group (JAG) for Gastrointestinal Endoscopy Accreditation in 2010. This is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the measures in endoscopy standards. A JAG visit took place in March 2015, the outcome was that accreditation was deferred for 6 months.
- Surgery carried out local audits to monitor quality of care. For example, actions had been identified following an audit of readmission rates after general surgery, which included reviewing discharge advice to patients, especially after inguinal hernia repair.
- Processes were in place to ensure that patients' nutrition and hydration were effectively managed prior to and following surgery. Patients received clear fasting instructions which followed the Royal College of Nursing pre operative fasting guidelines, 2005.
- Fluid input and output records were used appropriately to monitor patients' hydration. We looked at a sample of records on the surgical wards, which were completed to a good standard.
- A nutrition screening tool for inpatients was completed within the first 24 hours of admission, repeated weekly and action taken where required.
- Patients requiring specialist dietary advice were referred to the dietician and offered the most appropriate menu for example textured, low fibre, gluten free, standard or halal.
- Mealtimes were protected on wards and we observed staff giving positive encouragement and assistance, where possible with involvement from family and carers where required.
- Patients were satisfied with their meals and said they had a good choice of food and sufficient drinks throughout the day.

Pain relief

- Patients were regularly asked about their pain levels, particularly immediately after surgery, and these were recorded using a pain scoring tool. We reviewed a number of care pathway records and saw that pain relief for patients undergoing a variety of procedures was documented.
- The trust had a dedicated pain team that provided advice and support to the wards. Out of hours, ward staff could access the on-call anaesthetist.
- An enhanced recovery pathway was in place for patients admitted for orthopaedic procedures. Patients who underwent surgery followed a pathway developed to ensure they were provided with defined pre-operative, peri-operative and post-operative analgesia, which meant early patient mobilisation, independence and earlier hospital discharge.
- A three month epidural care package was being piloted on Keppel Ward. Staff told us they had received training and competency assessments and were able to provide pain management for patients using epidurals.

Nutrition and hydration

Patient outcomes

- There were no current CQC mortality outliers relevant to surgery at Rotherham Hospital. This indicated there had been no more deaths than expected for patients undergoing surgery at the hospital.
- The average length of stay was in line with the national trend in most specialties, although higher than the national average for some specialties (elective trauma and orthopaedics; non-elective urology; and elective and non-elective general surgery). The trust had identified there was a higher than average revision rate for joint replacement surgery.
- The trust scored slightly worse than the England average for non-elective and elective trauma and orthopaedics and non-elective general surgery readmission rates. (Hospital Episode Statistics 2013/14). All readmissions had been reviewed by the trust and they told us they were confident that there were no areas of concern.
- The trust participated in the National Hip Fracture Audit. Findings from the 2014 report showed that the trust was better than the England average in most areas and slightly worse for the percentage of patients developing

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pressure ulcers (3.6% against England average 3%). The trust acknowledged that there was a short period where there had been a change in ward leadership on one of the orthopaedic wards. During this time there were a small number of patients suffering pressure ulcer harm.

- Performance in the National Bowel Cancer Audit 2014 showed better than the England average results for multidisciplinary team discussion, clinical nurse specialist involvement and scans undertaken. Of patients undergoing major surgery, 68.7% stayed in the hospital for an average of more than five days (better than the England average of 69%).
- The National Emergency Laparotomy Audit 2014 showed that most of the 28 indicators were rated as 'not available'.
- The hospital outcomes for the Patient Reported Outcome Measures (PROM) April 2013 to December 2013 for hips, knees and groin hernia repair showed that the percentage of patients that had improved for each procedure was in line with those reported nationally.

Competent staff

- Staff had the right qualifications, skills and knowledge to do their job. Nursing staff undertook competency-based assessments to show they met the requirements of their role.
- Staff had opportunities in an annual appraisal to discuss their performance and identify learning and development needs. The figures for surgical staff appraisal rates in several areas were over 90%.
- Junior doctors in surgery told us they attended teaching sessions and participated in clinical audits. They said they had good ward-based teaching, were well supported by the ward team and could approach their seniors if they had concerns. The General Medical Council National Training Survey 2014 identified no risks in these areas.
- All junior doctors were assigned an educational supervisor. An initial meeting was held in the first two weeks of being in post. Named mentors were also available, providing trainees with a valuable resource for asking questions and discussing any issues.
- There was a clinical tutor in theatres who provided mentoring and support for staff. All new staff undertook a six-month learning programme which covered all areas of theatres and recovery.

- An induction checklist was used for agency staff which included orientation to ward layout and equipment sign-off.
- An apprentice in theatres gave positive reports of their learning opportunities at the trust, of staff being friendly towards them and of good working relationships within teams.
- Revalidation and completion of consultant job plans were on target.

Multidisciplinary working

- There was effective multidisciplinary team working on the wards. Daily ward rounds were carried out where the clinical care of every patient was reviewed by members of the multidisciplinary team, led by the consultant managing the patients' care.
- Staff told us there was effective communication and collaboration between teams, which met regularly to identify patients requiring visits or to discuss any changes to the care of patients.
- We observed an orthopaedic multidisciplinary team meeting which involved nursing and social services staff, the ward manager, discharge coordinator, occupational therapy and physiotherapy. All inpatients were discussed and complex issues addressed such as mental health concerns. Appropriate support plans were developed and patients referred to other specialisms such as palliative care, social services, nursing and residential care.
- Effective team working between ward and theatre staff was observed; interactions, interventions and treatment were recorded.
- Discharge letters were sent to the patients' GP and a copy of the letter provided to the patient.

Seven-day services

- Consultants were available on-call out of hours and would attend when required to see patients at weekends.
- Access to diagnostic services was available five days a week, with an on-call service outside normal working hours for plain film radiography, computerised tomography (CT) scans and ultrasound examinations.
- Physiotherapy and occupational therapy staff were available on the orthopaedic wards seven days a week.

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- Pharmacy services provided dispensing Monday to Friday from 9am to 7pm and on weekends and bank holidays from 9am to 3pm. At all other times, an on-call pharmacist was available.

Access to information

- Laboratory requests were mostly through the electronic patient record system. Routine haematology, biochemistry and microbiological investigations were available 24 hours. Blood samples were sent to the laboratory using a chute system, with high risk and urgent specimens taken by porters.
- Theatres used an electronic patient management system and staff had access to an online tablet to book patients in and out of theatres. This provided real time information on patient flow. We observed the process which took approximately four minutes for patients to be transferred to theatres. The process was efficient and resulted in minimal delays.
- All local policies and guidelines could be accessed electronically on the trust's systems. Local policies were written in line with national guidelines and updated every two years or if national guidance changed. For example, there were local guidelines for pre-operative assessments and these were in line with best practice.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Records showed that patients gave consent to treatment during the pre-assessment stage and this was reconfirmed on the day of surgery. We reviewed a sample of consent forms and found that most of these were completed appropriately and in line with Department of Health Guidelines.
- Consent audits showed good performance in a number of areas including use of appropriate consent forms and documenting risks and benefits. Improvements for informing the patient of the type of anaesthesia and provision of information booklets were identified and an action plan developed.
- All patients we spoke with told us they had been asked for their consent before surgery. They said the risks and benefits had been explained to them and they had received sufficient information about what to expect from their surgery.

- Staff had access to the trust's Mental Capacity Act 2005 policy, including its associated deprivation of liberty safeguards. Most staff had an awareness of the legislation and said that further training in these areas was being planned.

Are surgery services caring?

Good



The surgical service was caring.

We observed positive, kind and caring interactions on the wards and between staff and patients. The majority of patients spoke positively about the standard of care they had received.

Patients felt they understood their care options and were given enough information about their condition. There were services to ensure that patients received appropriate emotional support.

Compassionate care

- We observed patients being treated with compassion, dignity and respect.
- Most patients were spoken to and listened to promptly. Patients told us that staff were very approachable and they were happy with their patient experience during their stay. However, two patients said that the staff attitude could be improved and they felt some staff had not listened to their complaints.
- We saw staff introducing themselves appropriately and drawing curtains to maintain patient dignity. There were facilities on the wards for staff and relatives to have more sensitive conversations if required.
- Patient-led assessments of the care environment (known as PLACE) for 2014 showed the trust was slightly below the England average for cleanliness, food and facilities, privacy, dignity and wellbeing.
- Call bells on the wards were mostly answered promptly and were in reach of patients who needed them.
- Hourly intentional rounding (checks to make sure patients were comfortable and had what they needed) had been introduced to make sure that staff were aware of any emerging needs patients had.
- The response rate for the NHS Friends and Family Test was similar (32.8%) to the England Average (32%) for the period April 2013 to July 2014.

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- The test results were displayed on the wards we visited. Average scores were presented alongside the feedback received. Overall, the scores indicated positive responses on each ward, for example, for dignity and respect, involvement, information and cleanliness.
- Patients we spoke with said they would be happy for their family and friends to be treated at the trust.
- The CQC Adult Inpatient Survey 2013 did not identify any evidence of risk and the trust was rated 'about the same' as other trusts.

Understanding and involvement of patients and those close to them

- Patients said they felt informed about and involved in their care and treatment. We observed patients being kept informed throughout their time in the anaesthetic room and theatres.
- We observed nurses supporting patients and responding to their questions in a calm and caring manner.
- Detailed information was available for patients to take away about their procedure and what to expect. They were given contact numbers for specialist nurses to ensure that they had adequate support on discharge.
- In the Cancer Patient Experience Survey 2013/14, the trust scored in the highest 20% of trusts for patients being given a choice of different types of treatment, and in the middle 60% of trusts for how staff had explained how the operation had gone in an understandable way.
- Patients had the opportunity to visit orthopaedic wards to discuss the enhanced recovery programme prior to total hip replacement surgery.

Emotional support

- There was information in the care plans to identify whether patients had emotional or mental health problems. Assessments for anxiety and depression were done at the pre-assessment stage. Nursing staff provided extra emotional support for patients both pre-operatively and post-operatively.
- Patients told us that staff had made them feel at ease and they were not worried about their pending surgery.
- Clinical nurse specialists in areas such as colorectal, stoma, breast care and pain management were available to give support to patients.
- The mental health team provided a 24-hour service for patients with psychiatric problems or following episodes of self-harm.

Are surgery services responsive?

Requires improvement



The responsiveness of the service required improvement.

Staff were responsive to patients' individual needs, but there were concerns over issues such as; waiting times; the 18-week referral to treatment times; the high number of medical outliers on surgical wards; access and flow for patients attending the fracture clinic; and mixed-sex accommodation breaches on the SAU.

Services were available to support patients who lacked capacity to access the services they needed. Support was available for patients living with dementia and learning disabilities.

Information about the trust's complaints procedure was available for patients and their relatives. There was some evidence that the service reviewed and acted on information about the quality of care that it received from complaints.

Service planning and delivery to meet the needs of local people

- The service worked collaboratively with neighbouring trusts to plan and deliver services for the local population. Recent changes to meet the needs of patients and ensure efficiency of services included development of ENT, oral and maxillofacial and ophthalmic specialties.
- Surgical services were available 24 hours a day, seven days a week, with emergency access to operating theatres outside of normal working hours.
- The endoscopy service had made changes to improve service delivery to accommodate increased numbers of patients attending appointments and to meet mixed gender requirements. An extra waiting area had been created to act as an overflow areas and alterations to booking systems for some lists had resulted in fewer patients attending at any one time. The plan over the next 18 months was to develop a new endoscopy suite to meet increased patient demand.
- The trust had an escalation policy and procedure to deal with busy times. This gave guidance to staff on how to proceed when bed availability was an issue.

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Access and flow

- The trust had identified concerns with the waiting list management system following the validation of an 18-week referral to treatment pathway. A patient was identified who had been waiting for a total of 66 weeks since referral. A report to the trust board showed that immediate action was taken with a review of internal practices. This identified a number of patient pathways (around 13,000) that required validation. At the end of April 2015 a total of 10 patients had been identified as waiting beyond 52 weeks, and all were being closely tracked and monitored with care plans in place.
- The hospital surgical team could be accessed via a number of routes, including referral from the patient's GP for consideration of the need for elective surgery, emergency admission via A&E, on request from the GP or by self-referral.
- Patients were assessed by the multidisciplinary team, including an anaesthetist, before admission. This allowed staff to identify patients' care needs before their operation and have recovery plans in place.
- Discharge planning began at pre-operative assessment stage for elective patients and on admission to the unit for trauma or emergency patients. Staff reported that, where community services were required, these were arranged by referral to social services. There was a four-day turnaround time which sometimes resulted in the delayed discharge of medically fit patients. Data for August 2014 to January 2015 showed that 83 patients experienced delayed transfers of care at the trust. The most common reason was delays in completion of assessments. (NHS England, 2015)
- Theatres used an electronic centralised booking system which provided real-time tracking of theatre cases and management of theatre schedules. This was used with the aim of fully utilising operating lists and identifying potential empty slots on the lists.
- We observed a good model of care led by a band 7 emergency theatre practitioner who managed the theatre admissions unit. All patients waiting to go to theatre were regularly seen to ensure they were fully prepared prior to surgery. If the order of operating lists changed, the nurse revisited patients and kept them fully informed of any delays.
- Trust performance data for April 2014 to December 2014 showed that there were no urgent operations cancelled for a second time.
- The percentage of patients cancelled on the day of operation for non-medical reasons was better than the trust target of 0.8%.
- The scheduling of patients for morning or afternoon operating lists and their admission to the theatre admissions unit pre-operatively meant that patients were not fasting for long periods of time.
- The trust had outlier guidance, which included criteria for the suitability of patients to be transferred to wards which were not their primary ward. Staff reported that it was common practice for medical patients to be cared for on surgical wards. Data showed that, over a four-month period (August to November 2014) there were 195 medical patients placed on surgical wards. Staff told us that patients were reviewed by the medical teams, however, due to the length of stay of some medical patients this was impacting on surgical patient discharges and access and flow.
- Staff on Keppel Ward reported that medical and trauma patients were regularly placed on the elective orthopaedic ward. Trust data for January and February 2015 showed that 60% and 45% respectively of medical patients had been admitted to Keppel Ward. The trust had a standard operating procedure for patient placement and movement during a critical lack of bed capacity across the trust. In this situation, the balance of risk and a plan to move patients with the lowest risk of infection into the elective unit was made.
- There were difficulties with access and flow in the fracture clinic. Staff told us that clinics were overbooked and appointments regularly over-ran which resulted in delays and patient complaints about waiting times. An action plan had been developed which included a business case proposal for additional staff, establishment of virtual fracture clinics and for staff to receive competency assessments to allow them to work more flexibly in clinics.
- Results of the cancer two-week wait from referral to date first seen for all urgent referrals (cancer suspected) was better than the national target of 93%.
- Between April 2013 and March 2014 there was one patient whose operation was cancelled and who was not treated within 28 days. (NHS England, 2014).

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- Laparoscopic cholecystectomies (surgery to remove gallbladder) intended as a day case and performed as a day case was almost 98.697% compared to a peer rate of 910.9%. This meant the trust was performing better than other similar trusts.

Meeting people's individual needs

- The trust did not meet the requirements set by the Department of Health on eliminating mixed sex-accommodation in hospitals. Men and women were cared for in the same bays on the SAU. Between January and December 2014, there were 49 mixed-sex accommodation breaches. The directorate had identified this as a risk and were continually monitoring and reporting when mixed-sex bays occurred.
- The trust used the 'Forget me not' scheme which supported patients with dementia and delirium. There were 'dementia friends' on the wards who could provide advice and support on caring for people with these needs.
- Patients with learning disabilities were assessed using a 'traffic light' assessment tool which included key information about patients' communication abilities, physical care needs and other factors which needed consideration in arranging appropriate appointments.
- Theatre staff told us that patients with special needs were identified at pre-operative assessment and arrangements were made for carers to accompany the patient to the anaesthetic room or to be present in the recovery area shortly after the patient recovered from the anaesthetic.
- Input from an ortho-geriatrician was available 16 hours per week for elderly patients who had been admitted with orthopaedic matters.
- Discharge planning commenced at the pre-assessment stage and continued during admission, with specialists such as physiotherapists and occupational therapists identified and arranged while the patient was in the hospital. Delays to discharges were mainly due to external factors, such as community-based needs and referrals for a social services assessment.
- Patients using urological cancer services were allocated a key worker, who took a role in the coordination and continuity of the patient's care, including information, advice and access to other specialists when required. The Trust Board had approved 7.5 hours for a new

urology clinical nurse specialist post and a business case was in place to increase this to a full-time position which was in line with the Improving Outcomes: A Strategy for Cancer guidance.

- A translation telephone service was available for patients who did not speak English as their first language. There were multiple information leaflets available for different conditions and procedures. These could be made available in different languages.

Learning from complaints and concerns

- Complaints were handled in line with trust policy. Information was given to patients about how to make a comment, compliment or complaint. There were processes for dealing with complaints at ward level and through the trust's patient experience department.
- There had been 77 complaints regarding inpatient surgical care between January and December 2014.
- We looked at a sample of eight surgical complaints in September and October 2014. Examples of actions taken included ensuring that all patients admitted had the same level of clerking at admission, that name boards were up to date and the use of identifiers at bed heads regarding timing of medication for Parkinson's patients.
- Complaints management information formed part of the chief nurse report to the Trust Board. The latest trust performance data for January 2015 showed that there were 344 complaints trust-wide in the last 10 months against a trust target of 600.

Are surgery services well-led?

Good



The leadership in the surgical services was good.

The current senior leadership had a good understanding of their roles within the directorate and were aware of the risks and developments required to improve patient care. A number of developments were being implemented, however, it was too early to say whether these would be effective and sustainable.

There was an open and transparent culture on the surgical wards and staff were able to raise concerns and these would be acted on.

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The trust had governance structures in place and took part in clinical audit and clinical effectiveness programmes to try to improve the quality of care delivered by the hospital. However, governance frameworks were not yet fully embedded and work was on-going to ensure that processes were robust.

Patient and staff engagement was improving and there were a number of initiatives to further develop these areas.

Vision and strategy for this service

- The trust had a clear vision and strategy and this was displayed throughout the hospital. Some staff on the wards were aware of this strategy and the trust's planned changes to service provision.
- The strategy for the surgical directorate included increased collaborative working with neighbouring hospitals. Currently there were shared arrangements in place for ENT, oral and maxillo-facial surgery and ophthalmology. The directorate was exploring other potential opportunities for collaboration with providers in the local health economy.
- There were also plans to redesign endoscopy and the SAU to improve access and flow and reduce mixed sex-accommodation breaches; although, there were no definite dates for the plans to be achieved.

Governance, risk management and quality measurement

- The clinical restructure had introduced the new role of governance lead within the clinical management teams. The lead facilitated risk and quality checks and supported records maintenance to follow-up actions. The action plans for improvements were overseen and triangulated through the patient safety group and clinical effectiveness group. Issues were escalated via the trust board committee structures.
- Although directorate-level governance arrangements were in place, the frameworks were not sufficiently embedded throughout the organisation. For example, work was on-going to strengthen risk-mapping processes and staff knowledge of risk management and learning from incidents, complaints and claims.
- The matron for governance told us that work was ongoing within surgical specialties to update risk registers. A risk validation process was in place to review new and existing risks and agree the risk score prior to adding to the register.

- A number of band six nurses had been identified to act as patient safety leads. These staff were receiving external mentoring and learning sessions two days per month for 12 months. This was a trust wide initiative.
- Not all staff in theatre (surgeons, anaesthetists, operating department practitioners and nursing staff) were fully engaging and complying with the WHO surgical safety checklist. This was identified on the directorate risk register, and a 'task and finish' group had been set up to action issues.
- Most consultants felt that the new processes and systems had improved cross-departmental learning and quality assurance.
- Staff were able to tell us about the principles of the Duty of Candour, although they were unaware of the specific requirements of the new regulations (which had come into force in November 2014). They told us the trust was open and honest with patients following incidents and complaints in accordance with the trust's 'Being Open' policy.

Leadership of service

- In January 2014 a new directorate structure was established by consolidating the previous clinical service unit structure into four directorates. The surgical triumvirate was led by a director of clinical services, head of nursing and general manager. The senior management team told us the new structure felt effective as units were no longer working in isolation and the changes would improve patient care.
- The current senior leadership team within the directorate had a good understanding of their roles. They were aware of the risks and the developments needed to improve the quality of patient care. A number of developments were being implemented, however, it was too early to say whether these would be effective and sustainable.
- Staff and managers told us that, over the last few years, there had been many staff changes across all grades, which had led to a lack of confidence and accountability within the trust. However, most staff supported the new management structures and felt the recent changes would improve patient care and their work experience.
- Staff said the executive team, especially the chief executive, were visible. For example the chief executive had attended anaesthetic departmental meetings and participated in 'walkabouts' on the surgical wards.

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- Matrons and ward managers were in post within the directorate to oversee operational issues and assist with daily workforce planning to ensure staff were distributed according to clinical needs. Staff reported that matrons and ward managers were visible and accessible.

Culture within the service

- Most staff reported an open and transparent culture on the surgical wards. They reported good engagement at ward level, felt they were able to raise concerns, and that these would be acted on.
- We spoke with a consultant anaesthetist who said the new management structures had improved clinical input and engagement.
- Staff spoke positively about the service they provided for patients. High-quality, compassionate patient care was seen as a priority.
- Most surgical areas said they held staff meetings however some staff said they had not had a staff meeting for a few months.
- We saw that staff morale in theatres was good. There was effective communication between theatre and recovery staff. Management meeting minutes were available for staff to read. There were good theatre staff room facilities with access to a quiet area and computer terminals.
- Junior doctors told us they liked working in the hospital and that they had been well supported by the hospital teams and their colleagues. They also said they were provided with good training opportunities, which met their individual development needs.
- Staff sickness levels in surgery for January 2015 were 5.45% against a target of 5%.

Public and staff engagement

- The NHS Staff Survey data for 2015 showed that the trust had improved slightly on its score for staff engagement, with a score of 3.56 (compared to 3.54 for 2013) against the national average of 3.74. There were also improvements in the number of staff receiving personal development reviews. Fewer staff experiencing discrimination and bullying and fewer staff working additional hours compared to the national average. The negative findings were in areas such as motivation at work and ability to contribute toward improvements and staff believing that their role makes a difference to patients.

- The trust had been proactively encouraging and facilitating staff engagement. The chief executive was hosting 'Moving forward together' staff briefing engagement sessions which focused on the five overarching strategic objectives set out in the trust's five year strategic plan. The most significant change cited for future developments was the successful recruitment and retention of staff for all clinical areas. Staff noted that this was starting to happen and felt this would improve staff morale.
- Listening into Action and 'Pulse Check' surveys were ongoing. A chief executive's weekly email was sent out and staff feedback received via a link which provided an opportunity for staff to write confidentially to the chief executive. These were all trust side initiatives.
- In response to the staff survey, improvements identified in surgery included weekly sharing of information between service managers and matrons, introduction of staff suggestion boxes, summary of job roles and reporting of staff achievements.
- The trust took part in the NHS Friends and Family Test. Results were displayed in most clinical areas. However, in some areas while there were feedback noticeboards, there were no comments cards or posters informing patients about how to provide feedback or make a complaint.
- In October 2014 the breast care team held a forum for patients to feedback their experiences of the service. An action plan was developed with improvements in information for patients, changes to the breast care pathway and enhanced communication.

Innovation, improvement and sustainability







- There were systems in place to enable learning and improve performance, which included the collection of national data, audit and learning from incidents and complaints; however the processes were not yet fully embedded or implemented across directorates and were yet to be evaluated.
- The directorate provided some innovative techniques such as 'awake' anaesthesia for shoulder surgery. The surgery avoided potential side effects of general anaesthesia and resulted in a quicker recovery period, with most patients being able to go home the same day.
- As part of the enhanced recovery programme in orthopaedics, patients were active in the preparation

Surgery

and planning before admission, pre-operative assessment, recovery and early mobilisation. Patients were better prepared to cope when they were back at home.

- Staff spoke positively about the vascular access service. Nurse specialists supported wards to cannulate patients and provided 24-hour reviews of peripherally inserted central catheters to avoid infections.

Critical care

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

Information about the service

The critical care service at the Rotherham NHS Foundation Trust consisted of up to 14 beds divided between two adjacent areas: the intensive care unit (ICU) which had five beds and high dependency unit (HDU) which had eight beds. An extra bed was available in the ICU but, if it was used, two HDU beds would be closed. This enabled the critical care service to be flexible according to demand, while ensuring that the required nurse-to-patient ratio of 1:1 for level 3 care and 1:2 for the HDU was maintained.

The ICU provided level 3 care for patients requiring advanced respiratory support or basic respiratory support in conjunction with the support of other organs. The HDU provided level 2 care for patients stepping down from level 3 and for adults at risk of their condition deteriorating. There were no paediatric critical care beds in the department although, on occasions, a sick child may be brought to a side room for stabilisation prior to transfer to a specialist hospital.

A critical care outreach team reviewed directly referred patients who were identified as deteriorating or highlighted by the patient at risk (PAR) early warning score used by the trust. PAR is a modified version of the Modified Early Warning Score (MEWS) for identifying acutely ill patients. The outreach team also supported patients within the community who were on long-term ventilation and provided training on the use of the PAR score across the trust.

During our inspection, we spoke to 22 members of staff, including managers, nurses and doctors, allied healthcare

professionals, support and domestic staff. We spoke to three patients and six visitors. We observed care and treatment provided to patients. We looked at policies and guidelines and reviewed the notes of patients on the ICU and HDU. We also reviewed the notes of two patients who had been transferred from the HDU to a base ward.

Prior to our inspection, we received performance information about the trust and department-specific data in the form of a national critical care electronic data set, to which the critical care department subscribes and receives quarterly reports. This data related to the ICU beds only.

A key change proposed for the delivery of critical care was the integration of the ICU with the HDU, with the specialist intensive care consultant responsible for primary patient management.

Critical care

Summary of findings

Overall we rated the critical care service as "requiring improvement."

There were concerns that a poor incident-reporting culture existed within the department, with little evidence of sharing or learning from incidents or complaints.

The trust did not always meet the recommendations of the core standards for medical and nurse staffing in intensive care units. There were not enough critical care specialist consultants to provide 24-hour cover and specialist nursing supernumerary support was not always possible.

Security of the department was highlighted as a concern due to open access during the daytime hours.

The environment was clean and staff followed infection control procedures. NHS Safety Thermometer data indicated good patient outcomes with below average infection rates and no medication errors.

There was a lack of accessibility to current policies and guidelines which had led to use of custom and tradition rather than evidence-based best practice. Insufficient specialist critical care consultants resulted in patients not receiving specialist reviews within the timescales outlined in the critical care core standards.

The critical care service was generally effective in meeting patients' needs and the data available indicated that results were in line with the activity and outcomes of similar-sized units.

A recent high turnover of nursing staff meant there was a high percentage of newly qualified or inexperienced staff. The practice development nurse was sometimes allocated a patient to care for, resulting in reduced supervision of new staff.

The inspection team observed staff delivering care to patients and witnessed a caring and compassionate approach on every occasion. We spoke with patients and carers about their experiences on the critical care unit and found all their responses to be positive. The unit could access interpreters and multid denominational pastoral support when needed.

The department was a member of the North Trent Critical Care Network and had adopted the network's admission, transfer and discharge policies. The average length of stay in the unit was consistent with other similar-sized units.

Complaints and concerns were dealt with at senior management level. We saw no evidence that complaints or concerns were discussed at staff meetings or that any changes had been made in response to a concern or complaint.

There was no clear vision for the future development of the department. The risk register was not fit for purpose and was found to include risks that dated back to 2010, without a clear outcome from actions.

Critical care

Are critical care services safe?

Requires improvement 

We judged the safety of the critical care service as 'requires improvement'.

There were concerns that a poor incident-reporting culture existed within the department, with little evidence of sharing or learning from incidents or complaints.

Medical and nurse staffing levels were inconsistent and did not always meet the levels recommended within the core standards for intensive care units. There were not enough critical care specialist consultants to provide 24-hour cover and specialist nursing supernumerary support was not always possible.

Security of the department was highlighted as a concern due to the open access available during the daytime.

The environment was clean and staff followed infection control procedures. NHS Safety Thermometer data indicated good patient outcomes with below-average infection rates and no medication errors.

Incidents

- Incidents were reported using the trust's electronic reporting system and staff informed us that they were familiar with the process for reporting incidents, near misses and accidents. However, it was evident that not all incidents were reported appropriately. For example a near miss medication error was identified by an inspection team member which had been corrected but not reported onto the electronic system
- The critical care department provided the inspection team with information about reported incidents. There had been 139 incidents reported during the twelve month period of January 2014 to January 2015. This included one serious incident requiring investigation (SIRI) The SIRI was a grade 4 pressure ulcer which following investigation was found to be an unavoidable outcome for the patient due to immobility and clinical instability.
- Staff informed us that learning from incidents took place and that they were discussed at staff meetings. There was also a communication folder. We reviewed the folder and found there was no way of establishing which

staff had read the communication or whether they had acted upon the information provided. Staff spoken to were unable to recall examples of changes in practice that had taken place as a result of an incident.

- We read the minutes of staff meetings and found that incidents did not feature on the agenda. We were therefore not assured that incidents were discussed or that learning was shared across the team.
- A member of the nursing staff informed the inspection team that there was a lack of support for those reporting incidents and that there was nervousness about reporting issues. An example quoted related to an incident about staffing levels which the reporter felt was unsafe. The feedback received was that the report was unwarranted.
- The majority of staff including doctors, nurses and allied healthcare professionals told us that patients and their relatives would be informed of any errors or problems that had affected them. 'Duty of candour' or being open and honest about any actual or potential adverse incident is a requirement of all staff.

Safety thermometer

- The NHS Safety Thermometer is a tool used for measuring, monitoring and analysing patient harm and harm-free care. Information was clearly displayed for patients, staff and visitors to see.
- The January 2015 Safety Thermometer display indicated 100% for infection control with no incidents of methicillin-resistant staphylococcus aureus (MRSA), Clostridium difficile (C. difficile) or central line infections. There was one fall recorded with no harm and no medication errors.

Cleanliness, infection control and hygiene

- The department was clean, uncluttered and odour free. However, we noted some high level dust on the ICU pendants – pieces of equipment that provide access to oxygen, suction and power points at each bed space.
- There was noted to be adequate space between each bed with areas to accommodate equipment and visitors comfortably.
- The Intensive Care National Audit & Research Centre (ICNARC) data showed low levels of infection rates in the ICU. The report confirmed no MRSA or C. difficile

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infections for the survey period April to September 2014. This was in line with other general critical care units of a similar size that had participated in the ICNARC Case Mix Programme (CMP).

- Staff were seen adhering to the trust policy on infection control. The 'bare below elbows' best hygiene practice policy was followed and personal protective equipment, such as gloves and aprons, were readily available. We observed staff using personal protective equipment and changing them when moving between patients. There was adequate hand-sanitiser dispensers throughout the department and visitors were reminded to use it on arrival to the department. There were adequate hand-washing facilities throughout the department and staff washed their hands before and after patient contact.
- There were two side rooms within the ICU that had air-flow systems to prevent airborne infection risk.

Environment and equipment

- The critical care department including the ICU, HDU and connecting corridors, were clean and uncluttered.
- There was a dedicated room for the storage of equipment which was well-ordered. Staff told us there was enough equipment for all the commissioned beds and that equipment was available for use as required.
- Maintenance of equipment took place through the manufacturers' warranty and was supported by in-house medical electronics. The critical care department did not employ technicians. We saw the equipment was labelled as clean and ready to use.
- We saw a medical device training log which indicated an overall compliance of 96% for the nurses. There was an action plan to deal with shortfalls identified, such as training for newly employed staff or those absent due to sickness or maternity leave.
- There was no established rolling programme for the replacement of equipment. Any new equipment required the submission of a business plan
- Resuscitation equipment was stored in an accessible position and we found the daily checking records were up to date. The defibrillator had an up-to-date accuracy testing label and portable suction was available, although there was piped suction at each bed space. The resuscitation equipment was checked and sealed after each use.
- Patient transfer equipment, including an adult portable ventilator, was stored in the clinical room. Children were

not generally admitted to the department, however, paediatric resuscitation and transfer equipment was stored in the department for use should a child be transferred to a specialised unit.

- The adult transfer trolley was out of order on day one of the inspection due to a faulty side rail. This fault had been identified the day prior to the inspection and had been reported to the manufacturer. It was repaired during our inspection period. A rucksack used to carry disposable items for patient transfer was kept with the transfer trolley. All items were in good order and in date. Any medication required was added at the point of transfer.

Medicines

- The department was supported by a 0.1 whole time equivalent (WTE) band 8 pharmacist. This was below the Core Standard for Intensive Care Units (2013) recommendation of 0.1 WTE specialist clinical pharmacists for each ICU (level 3) bed or two HDU (level 2) beds which equated to 0.9 WTE. There was no current plan to increase this establishment. The pharmacist visited the unit every week day, but was not always available to join the consultant ward round. Pharmacy support was available on call over the weekend.
- Medicines were stored in locked cupboards, in accordance with legal and policy requirements, and the book recording the use of controlled drugs (those which require the signature of two registered professionals) was consistently signed by two individuals for each use. The stock level matched that in the record book, in accordance with legal requirements.
- There were two fridges for the storage of temperature-sensitive drugs. One was locked and one was open. The open fridge contained emergency medication that needed to be accessed quickly. Both refrigerators were stored in a treatment room. Fridge temperatures were being monitored and were found to be within the required range to keep medication safe.
- On day one of our inspection, we noticed that one of the door locks to the treatment room was broken. There was also a sticker on the door indicating the entry code for the lock. This meant that medication could have been easily accessed by those without the right to access it. We escalated our concerns to the matron and action was taken to repair the lock and remove the entry code sticker.

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- There were three grab boxes which contained drugs for urgent use, stored out of sight in an unlocked cupboard in the treatment room. These boxes were sealed with tape and labelled with their contents. One of the boxes was incorrectly labelled and one had a broken seal. Also, the list of drugs on the outside of the cupboard door indicated that one item had been out of date since October 2014. These boxes were reportedly checked every Monday morning or after use. The error was pointed out and immediately rectified.
- Medication charts were completed by hand and were found to be mainly clear, with signatures and block capital names of the prescribers included. Charts were checked by a pharmacist each day of the week.

Records

- Medical and nursing records were stored at the bottom of each patient's bed with documentation pertaining to current treatment in colour-coded files for ease of identification and access.
- Patients' names were covered up on the top of the observation chart which demonstrated an awareness of patient confidentiality and information governance.
- Medical and nursing records were updated and signed daily. Care plans were updated according to patients' clinical conditions. The majority of patient risk assessments were found to be fully completed and appropriate care plans were in place.

Safeguarding

- Staff expressed an awareness of their responsibilities and procedures for safeguarding of vulnerable adults. However, formal training on this was recorded as only 18% for the department. The trust target for training was 100% and this deficit was recognised by the senior nurse who was in the process of arranging specific training for the staff.
- The inspection team witnessed patients' verbal consent being appropriately obtained prior to interventions by all professionals involved in their care.
- Three patients told us they felt safe, informed and supported by staff on the unit.

Mandatory training

- Mandatory training was mainly completed online and staff reported difficulties in finding enough time to complete the modules. Records indicated 82% achievement for manual handling, 90% for fire safety

training and 81% for resuscitation training. However, completion of other training areas was consistently low, including adult safeguarding (18%), dementia care (53%) and information governance (59%). The trust target for all these subjects was 80%. The reason for the low levels was given as lack of availability and cancellation of training sessions across the trust. The possibility of training sessions in the department was being investigated. Staff appraisals were recorded as 89% complete.

Assessing and responding to patient risk

- Within the ICU and HDU, close observation enabled a rapid response to any identified deteriorating patients. There was a specialist intensive care consultant available for the unit from 8am to 8pm week days and a consultant anaesthetist on call overnight and on weekends. Patients in the HDU were managed by their speciality team, supported by the critical care team. It was reported that access to the specialist team was rarely difficult and a consultant was always available for support.
- The outreach team were working to educate ward staff in the application of the PAR early warning score, the trust's version of the Modified Early Warning Score (MEWS) for identifying acutely ill patients. The MEWS system is a nationally recognised patient assessment tool that scores a patient in relation to regular clinical observations such as temperature, pulse, blood pressure and respiratory rate. The score is an aid to recognising a deteriorating patient and gives clear instructions regarding the care escalation needed, based on the score. This ranges from increased frequency of clinical observations to urgent assessment from a doctor. The investigation team reviewed four patients' notes on the ICU and HDU and found the PAR chart had been completed and escalated appropriately prior to their admission. In addition, two sets of patient notes were reviewed on a surgical ward following discharge from the ICU, and these were completed and acted on in accordance with the trust policy.

Nursing staffing

- The staffing establishment across the HDU and ICU was 58.3 WTE with 3.18 WTE vacancies. This ensured that the nurse-to-patient ratio of 1:1 for ICU and 1:2 for HDU was maintained. However, the number of qualified nurses on

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shift did not consistently include a supernumerary clinical coordinator at peak times as recommended within the Core Standards for Intensive Care Units (2013).

- There was a matron with overall responsibility for the nurse management of the critical care department. The matron worked alongside the service manager on the operational and strategic management of the department. This was in line with Core Standards for Intensive Care Units. The matron's role also included responsibility for trauma and elective orthopaedics, rheumatology and community podiatry surgery. Staff told us that the matron was not always available on the unit due to other commitments.
- Following a recent restructure, there was one band 7 sister, nine band 6 (ICU-trained nurses) and 41 band 5 nurses. In total, 51% of the nurses had completed the critical care course, four will complete the course in June 2015 and four will start the course in September 2015. This was in line with the recommended level.
- Prior to the inspection, the information provided stated that the critical care department did not employ agency staff. However, during our inspection we observed that an agency nurse had been employed for a night shift.
- Trust bank staff were used to fill gaps in the rota. These nurses had worked within the critical care department or had ICU experience. The matron assured us that the number of hours worked by staff was closely monitored to avoid potential tiredness. Sickness levels were also closely monitored. Some nurses expressed concerns about the number of hours worked by certain individuals, although staff records did not support this concern.
- On average, sickness level for nurses on the unit for April to December 2014 was 3.69%. This was below the Royal College of Nursing identified average of 4%.
- Nursing staff expressed concerns about the number of times they were being moved to other departments to cover staff shortages. This issue had also been raised at exit interviews with the human resource team. Information supplied by the trust indicated that staff moves had become frequent, with 13 recorded moves in September 2014 and 12 moves in October 2014. All moves affected band 5 nurses and occurred on day and night shifts.

Medical staffing

- Medical staffing included a critical care specialist consultant lead who was given protected time for this role.
- On week days there were two critical care specialist consultants covering the morning and one for the afternoon and evening shift. There was a shortage of critical care specialists, resulting in cover being provided by general anaesthetists. The lead clinician recognised this shortfall in critical care intensivist cover and there are were plans to recruit a further consultant to bring them up the number to 8 eight WTE.
- There was on-call consultant anaesthetic cover overnight, from 8pm to 8am week days and on weekends. Access to a critical care specialist consultant was by telephone for specialist advice. There was cover provided by a registrar who also had a responsibility for obstetric cover.
- The critical care consultant rota was compiled day-to-day, and so there was a risk of inconsistency in decision-making.
- There was a medical handover each morning and a critical care consultant ward round which took place between 11.30am and 1pm. The inspection team was concerned that this was late in the day to facilitate changes in treatment; although, we did not find clear evidence this was the case. It is recommended in the Core Standards for Intensive Care Units that two ward rounds take place each morning and evening.
- HDU patients were managed by their individual speciality consultant surgeon or physician, supported by the anaesthetic team. Patients were reviewed daily, although not at a pre-set time. The staff called the speciality team about HDU patients when further advice was required. They stated that there was very rarely a problem getting advice or support when needed and that critical care assistance was always on hand.

Major incident awareness and training

- The major incident folder was available on the unit. A service-specific card system was used to identify specific actions to be taken by each department. All senior staff was fully briefed on this. Staff we asked were aware of the major incident folder and where to locate it.

Security

- The doors to the department were open from 8am to 8pm which allowed free access to the unit by staff and public. The reason stated for this was that it allowed

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trolleys to enter without the risk of damage to the doors, something that had occurred previously. The inspection team raised this as a concern due to the vulnerability of patients in the critical care department. Access to the ICU was via a second double door and a reception desk, however, this desk was not staffed 24 hours and, therefore, people entering the area could go unchallenged. Entry into the HDU was direct from the department corridor and could also go unchallenged. The investigation team did not witness unchallenged entry but did raise the risk with the matron who stated that staff would always challenge anyone entering the ICU or HDU.

- At night the doors into the critical care unit from the main hospital corridor were kept locked and entry was only via a direct intercom system.

Are critical care services effective?

Requires improvement



The effectiveness of the critical care service required improvement.

There was a lack of accessibility to current policies and guidelines which had led to use of custom and tradition rather than evidence-based best practice. Insufficient specialist critical care consultants resulted in patients not receiving specialist reviews within the timescales outlined in the core standards for intensive care units.

A recent high turnover of nursing staff meant there was a high percentage of newly qualified or inexperienced staff. The practice development nurse was sometimes allocated a patient for a shift, resulting in reduced supervision of new staff.

The critical care service was generally effective in meeting the needs of patients treated within the unit and the data available indicated that it was in line with the activity and outcomes of similar-sized units.

Evidence-based care and treatment

- There was a lack of evidence relating to the availability of guidelines and policies for nurses and doctors on the unit. Staff indicated that guidance was readily available electronically, but when asked to demonstrate this, they were only able to find four guidelines, all of which had

expired review dates. There were paper copies but these were not easily useable as they were locked away, not filed in any structured order and incorrectly formatted. Much of the information was in the form of articles copied from journals.

- The critical care department was a member of the North Trent Critical Care Network and had adopted the network's policies for patient admission, transfer and discharge. Paper copies of these policies were available on the ICU and laminated summaries were visible on noticeboards.
- There was evidence of active involvement in audit and research by the medical trainees who stated that they felt very supported in this by the consultants. Audit activity was presented at multidisciplinary team meetings. Examples of audits included the ITU compliance with the Royal College of Anaesthetists 4th National Audit Project (NAP 4) including recommended actions (airway management), National Cardiac Arrest Audit, HDU admission review and patient handover documentation.
- The use of care bundles for ventilated patients and for intravenous access care was well-established and understood by the nurses caring for patients. This was evident from documentation and discussions.
- Multidisciplinary mortality and morbidity meetings took place each month. In addition, there was a mortality review and journal club which had recently been established. Both were well-attended by doctors but poorly attended by nurses and other healthcare professionals. Staff told us this was because of their workload, shift patterns and the timing of the meetings.

Pain relief

- Pain management on the unit was found to be effective. This was provided by the trust pain management team who visited each week day. Until recently, patients with epidural pain relief were admitted to the HDU. There had been a trial extending the service to orthopaedic wards which had been successful in reducing the length of stay for those patients. There were plans to extend this to other wards. This was expected to reduce the demand on HDU beds.
- Patients said that they received pain relief as required. The inspection team observed patients being asked about their pain level using the numerical score of 0 (no pain) to 10 (excruciating pain).

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Vascular access

- There was evidence of care and treatment being provided in line with best practice, including the recommended National Patient Safety Agency (NPSA) methodology for reducing venous catheterisation infections. The unit's Matching Michigan score was 0.3. The Matching Michigan score is an accepted scoring methodology for the incidence of venous infection as a complication of venous catheterisation. A score of 0.3 is a very low, indicating that the incidence of infection was negligible.
- A nurse specialist inserted central venous pressure and peripheral inserted catheters lines using infection control guidelines. These lines provide access to larger blood vessels for the administration of fluids, nutrition and medication. The aseptic technique used had resulted in the low infection rate. The vascular access team was also teaching doctors and nurses 'good flushing' techniques to prevent peripheral venous cannula infections.

Patient outcomes

- Currently ICU data was collected daily by a data clerk and submitted to the ICNARC programme. ICNARC produce quarterly reports about intensive care units in England based on a comparison with similar type and sized units across the country. Data was collected for the five-bed ICU activities only. There were plans to include data from the eight-bed HDU from 1 April 2015. Occupancy for ICU was recorded as 80%.
- The published ICNARC data from quarter three, April to September 2014, indicated that the outcomes for patients in the unit were broadly in line with that of similar units across the country.

Competent staff

- Fifty-one percent of nursing staff had a post-registration qualification in critical care nursing, with more nurses due to undertake the course this year. This was in line with national guidance which recommends 50% of nurses hold a post-registration qualification.
- There was a band 6 practice development nurse with responsibility for the development of nurses within the critical care department. This nurse provided clinical supervision for all new staff who were given supernumerary status for four to six weeks. This meant that new staff were supported and supervised in their

practice until they had completed their initial competency package. Staff were then expected to complete further competencies before they were eligible to undertake the post-registration qualification in critical care nursing. It was noted that the practice development nurse had to take responsibility for a patient for the duration of a shift which reduced availability for direct supervision. This does not meet the core standards for intensive care units for supporting and developing staff. Staff described this as a regular occurrence, but we did not find evidence that this was monitored to be able to quantify how often it happened.

- Trust information identified that 89% of staff had received an appraisal up until January 2015. All of the staff we spoke with told us they had received their appraisal and had agreed and understood their personal objectives. Staff with outstanding appraisals had agreed dates in the diary, with the exception of those on maternity or long-term sick leave.
- Staff were trained in recognising the deteriorating patient. This was supported by a critical care nurse consultant who also had responsibility for managing the critical care outreach team.

Medical staff

- There was a dedicated clinical director for the unit who was appropriately qualified.
- All trainees were actively involved in audits and presented these at the monthly mortality and morbidity meetings. All the trainee doctors we spoke to said they felt well-supported working within critical care and one had returned to the unit because the educational support and clinical learning was so good.

Multidisciplinary working

- There was evidence of good multidisciplinary team working. Therapy staff and other professionals, such as dieticians, microbiologists and pharmacists, worked closely with staff based on the unit and were seen to be involved in the ward round and decision-making processes.
- There was a good atmosphere between the doctors and other healthcare professionals on the unit. This encouraged an openness of debate regarding treatment options and promoted learning within the unit.
- The outreach team routinely checked on patients who had received level 3 care by visiting them on the ward

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and also inviting them back to a follow-up clinic. Patient survey forms given to those attending these clinics were very positive, with patients commenting that they were reassured by the information given and by having a chance to discuss their critical care stay.

Seven-day services

- There was no critical care consultant-led multidisciplinary ward round at the weekend. This meant that patients did not receive a specialist consultant review every 12 hours, seven days a week, as recommended by the core standards for intensive care units.
- The critical care outreach team worked from 8am to 6pm Monday to Friday. Access to clinical advice outside of these hours was through the registrar on call for critical care. The vascular access team was available seven days a week.
- Access to a respiratory physiotherapist was available seven days a week although, for the last seven months, this had only been possible because the physiotherapist had been working overtime at weekends to provide cover during a period of peak activity, described as 'winter pressures'. This was not sustainable.
- Speech and language services were available during the week.
- All nursing staff were trained in assessing patients' ability to swallow following extubation (removal of an endotracheal breathing tube).

Access to information

- Patients and visitors said that they were kept informed about treatment and progress.
- We saw that, where communication had taken place, this had been documented in patients' medical and nursing records.
- There was a range of information leaflets available in a rack that included information about the unit, a visitors' guide, NHS Friends and Family Test questionnaires, critical care follow-up services and how to raise a concern or complaint.
- All information was in English but stated that it was available in other languages or Braille on request. Staff were aware of and knew how to access the LanguageLine service should an interpreter be required. They also told us that switchboard personnel had a list of employees within the trust who spoke a second language.

- Staff used communication tools with patients who were unable to communicate verbally. These included picture boards and electronic devices.

Consent and Mental Capacity Act

- Staff introduced themselves by name when approaching patients and used patients' preferred name. Patients were also observed to be informed verbally prior to any nursing, medical or allied healthcare professional intervention.
- We reviewed the medical notes of surgical patients on the ICU and found the consent forms to be legibly signed and completed correctly, including a comprehensive list of possible outcomes. Evidence was also noted of discussions with those close to the patient about the treatment plans for patients unable to be involved in decision-making due to their medical condition. The multidisciplinary team discussed treatment plans at the daily ward round.
- We were told there was limited availability of training sessions within the trust for Mental Capacity Act 2005 and associated safeguards, and that the department was awaiting guidance and documentation regarding assessing capacity and acting on the patients' best interests.

Are critical care services caring?

Good



The caring shown in critical care services was good.

The inspection team observed staff delivering care to patients and witnessed a caring and compassionate approach on every occasion.

We spoke with patients and carers about their experiences on the critical care unit and found all their responses to be positive.

Compassionate care

- Staff clearly demonstrated a caring approach to patients. They were observed talking to patients, offering reassurances and explanations to them about their surroundings. This included orientating them to time and place.
- Visitors were welcomed and spoken to with respect and empathy.

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- Patient privacy was protected at all times with the use of curtains or blinds. The CCTV facility in the side rooms was switched off while the patient received any personal care. Notices were visible to inform people that personal care was taking place.
- Patients awaiting transfer to a base ward did not have the option of separation by gender, however, where possible privacy was maintained using the screening facilities available.

Understanding and involvement of patients and those close to them

- We spoke to seven visitors to the unit who were all very complimentary about the compassion of the staff. We spoke with one family who told us they had received a lot of information and the staff were very caring.

Emotional support

- Doctors, nurses and other healthcare professionals actively supported people's emotional needs. This included talking to them, holding their hands or providing refreshments for visitors.
- The critical care outreach team visited patients prior to and post discharge from the critical care department and held follow-up clinics for patients who had an extended stay on the unit. Patients were invited back to clinic three months after discharge from hospital as an opportunity to discuss the treatment they received and any emotional effects the admission may have had. We were shown questionnaires completed by patients attending the follow-up clinic. These were very positive saying that the clinic had helped them understand some of the "strange thoughts" they had experienced since being discharged from the ICU.

Are critical care services responsive?

Good



The responsiveness of the critical care unit was good.

The department was a member of the North Trent Critical Care Network and had adopted the network's admission, transfer and discharge policies. The average length of stay in the unit was in line with other similar-sized units.

Language interpreters and multi-denominational pastoral support could be accessed when needed.

Complaints and concerns were dealt with at senior management level. We saw no evidence that these were discussed at staff meetings or that any changes had been made in response to a concern or complaint.

Service planning and delivery to meet the needs of local people

- The critical care department was an active member of the North Trent Critical Care Network which was established to enable critical care units to work together within managed groups and to develop common evidence-based policies, guidelines, protocols and best practice. The department had adopted the network's patient admission, transfer and discharge policies.
- ICNARC data indicates that the ICU had an average occupancy rate of 80% which reflects that of similar-sized units across the country. This meant that the ICU was able to meet the demands for admissions from within the trust.
- There had been no cancelled operations due to critical care bed availability in the last 12 months.

Meeting people's individual needs

- Critical care beds were available when they were needed.
- There was information in the critical care department about 'dementia friends' and staff told us there were actions in place to increase awareness of people living with dementia. The matron was in the process of arranging a series of bespoke training sessions for staff and there was an information poster in the department.
- Multi-denominational pastoral support was available through the switchboard if required.
- Translation services were available through the LanguageLine service and through in-house dual language speakers listed at switchboard.

Access and flow

- There was no evidence of available operational or escalation policies to support bed management. The inspection team attended the regular morning trust bed meeting and observed shared information about bed availability and discharges. Critical care beds that were booked were confirmed as available at this meeting as well as declaring which patients may be able to be discharged from ICU or HDU.

Critical care

- ICNARC data indicated that the average length of stay in the ICU was five days, which reflects that of similar-sized units.
- Bed occupancy was 80% and there had been no cancelled elective operations as a result of there being no critical care bed.

Learning from complaints and concerns

- Complaints and concerns were dealt with at senior management level. We spoke with staff and reviewed the notes of staff meetings but we found no evidence that complaints or concerns were discussed or that any changes had been made in response to a concern or complaint.

Are critical care services well-led?

Requires improvement 

The leadership of the department required improvement.

There was no clear vision for the future development of the department. A key change for the department was the proposed integration of the ICU with the HDU, with the specialist intensive care consultant responsible for primary patient management.

The risk register was not fit for purpose and was found to include risks that dated back to 2010, without a clear outcome from actions.

There was a lack of support for incident reporting and no demonstrated learning from complaints or incidents.

Vision and strategy for this service

- There was no clear vision or written plan for the critical care department.

Governance, risk management and quality measurement

- Quality measurements in the form of the NHS Safety Thermometer were clearly displayed, with consistently good outcomes, which reflected those of similar-sized units. These outcomes were readily available for senior managers, if requested, for presentation at board level.
- We viewed the risk register and found it to be inadequate. It did not include a comprehensive, up-to-date list of assessed risks and included items dating back to 2010, without stated outcomes or action

planning. The register did not reflect the current risks within the department relating to 24-hour band 7 supernumerary support for the combined HDU/ITU or the ability to provide specialist consultant review every 12 hours, seven days a week.

Leadership of service

- This service was led by a specialist intensive care consultant anaesthetist who told us they were proud of the staff working in the critical care department and the integrated approach to care. The lead clinician had dedicated time for management of the critical care department.
- The clinical lead recognised that the department needed to increase the number of critical care specialist consultants in order to meet the core standards for critical care units. This included providing for 24-hour availability of a specialist critical care consultant to undertake twice-daily specialist ward rounds and respond to requests for advice or patient review within 30 minutes. This requirement was under discussion and a meeting with the consultant anaesthetists was planned to develop a suitable rota.
- Doctors in training told us they felt well-supported on the unit and were able to achieve their objectives and portfolio requirements.
- There had been a considerable amount of reorganisation within the nursing structure and this was not yet fully embedded. The role of the matron in particular had changed substantially – it now included managing critical care, trauma and elective orthopaedics and a community podiatry service, which meant a reduced presence in the department.
- Staff raised concerns with us about the style of leadership on the unit and they did not always feel confident to raise concerns with their line managers.
- Staff appraisals were established and clear objectives were set.
- The service manager felt comfortable about escalating any concerns to the general manager and was confident that any support required would be provided.

Culture within the service

- Doctors reported a good atmosphere and described the unit as a good place to work. This was observed during ward rounds and handovers which encouraged open discussion about treatment plans.

Critical care

- There was a mixed response from the nursing staff, with some staff feeling less supported than others. Some staff also raised concerns about having to be redeployed to work in other areas of the trust and said it made them feel undervalued.
- There had been a substantial turnover of nursing staff since the reorganisation and the practice development nurse was working hard to support newly employed nurses. However, they were not always able to be supernumerary which reduced the availability for direct clinical supervision. Due to a recent increase in new staff, there was pressure on the practice development nurse to work with staff to complete their competency packages.
- Some nurses felt intimidated by the pressure to complete competency packages. They had received formal letters stating a requirement to complete competencies within a set timetable, which they felt unable to do.

Public and staff engagement

- A patient questionnaire was in use and patients were asked to complete it. This was often done prior to leaving the unit and with the help of a member of staff. One nurse said, “we often help them fill in the questionnaire before they leave”. This could influence the answers given by patients.
- The patient survey results were displayed on the unit and demonstrated a general satisfaction across the


board, with scores of 80% to 90% in relation to patient safety and care provision. Two areas that scored low were for noise on the unit and provision of information prior to discharge.

- Visitors to the unit spoke very highly of the doctors and nurses caring for patients on the ICU and HDU.
- All staff were encouraged to attend ward meetings, the monthly mortality and morbidity meeting and journal club meetings. These were well-attended by doctors but poorly attended by nurses who said this was due to workload, shift patterns and staff moves.
- Long day shifts (12 hours) were in place and nurses were generally happy with this, although staff felt that this prevented them from attending meetings.

Innovation, improvement and sustainability

- There was a plan to increase the critical care specialist consultant numbers from seven to eight WTE and the lead consultant was in negotiation with current critical care colleagues to improve the rota. It was anticipated that this would enable the department to meet the core standards for specialist patient reviews.
- There was active involvement with the critical care network.
- The key change for the department was the proposed integration of the ICU with the HDU, with the specialist intensive care consultant responsible for primary patient management.

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

Information about the service

The Rotherham Hospital provided gynaecology services as well as a consultant-led maternity unit.

The gynaecology unit provided inpatient and outpatient services for the trust and saw around 9,300 outpatients each year.

Each year about 2,900 women delivered their babies at the unit, although this figure was expected to decline in 2014/15.

There was an antenatal clinic in the hospital as well as a combined antenatal and postnatal ward for women which also had a day unit. One bay in the ward was specifically for antenatal women, although bays were used flexibly as required. An early pregnancy assessment unit and pregnancy advisory service were located adjacent to the gynaecology ward.

There was one dedicated theatre in the maternity unit which was used for elective and emergency surgery. The main hospital theatres were used for gynaecological surgery or if there was a second obstetric emergency.

The hospital employed community midwives to care for women and their babies antenatally and postnatally; all community midwives were aligned to a GP practice.

We visited all inpatient areas of the gynaecology department and consultant-led maternity service. We talked to staff, spoke with patients and reviewed patient records as well as other documentation.

Summary of findings

Overall, the maternity and gynaecology service required improvement.

We were concerned about staffing levels in each area of the maternity department. We were told by staff that there were insufficient staff allocated to each shift and that, on occasions, shifts were below the trust's minimum requirement either due to sickness or because midwives were transferred from the antenatal/postnatal ward to work on the labour ward, leaving their own ward short of staff. Although the trust had an escalation policy, this was not always applied in practice.

The trust had a system to report and investigate incidents. Some of the staff said they did not always have time to report incidents, particularly about short-staffing, and the busier the department, the harder it was to find the time to do so. We saw evidence that lessons had been learned from incidents reported and that these were shared with staff.

Arrangements for assessing and responding to patient risk were not sufficient and there was a risk that patient safety needs may be overlooked because appropriate prompts were not included on all documents. Mandatory training levels were below the trust's target for all staff groups.

Safeguarding arrangements were in place, although improvements were needed for completion of

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documentation. Processes needed to improve for women with social service involvement who had delivered their baby and may need an extended stay on the ward.

There were arrangements in place to audit the care and services provided. While it was identified through audit that some standards had improved, others had not and were still poor compared to the England averages.

Outcomes for women were variable. There was a high rate of births being induced and, of those, a significantly higher rate of emergency caesareans than the England average. The perineal tear rate fluctuated and was very high some months, with no consistent upward or downward trend. We saw that some midwives were responsible for providing care for women recovering from surgery, but they had not received adequate training to do so. There was a lack of midwives trained to perform basic tasks, for example, suturing and cannulation as well as new-born baby checks. This impacted on the flow in the department as reliance was on a limited pool of staff.

We saw that women received pain relief as required and adequate arrangements were in place to ensure women and their babies received nutrition and hydration. Seven-day services and multidisciplinary team working were good and staff had an understanding of the Mental Capacity Act 2005.

The women and relatives we spoke with all reported that they received a good standard of care from all members of staff. They told us that staff were busy but caring and that information had been explained to them about their treatment.

We saw, and were told, that the maternity department was often very busy and that staff did not always have time to provide individualised care. The acuity of women was high and there were a high number of women with social needs who delivered their baby at the hospital. This meant that more time needed to be dedicated to a significant proportion of the women who attended the hospital.

There was a clear governance structure, although action plans could be clearer to ensure that these were followed up. The accuracy of discussion around

performance could be improved to ensure that it reflects the performance being achieved and any required improvement actions agreed and documented.

There were clearly defined accountability arrangements and staff felt well-supported by their immediate line manager, although some commented that they rarely saw senior managers on the wards or in the community.

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Are maternity and gynaecology services safe?

Requires improvement 

The safety of the maternity and gynaecology service required improvement.

We were concerned about staffing levels in each area of the maternity department. We were told by staff that there were insufficient staff allocated to each shift and that shifts were sometimes below the trust's minimum requirement, either due to sickness or because midwives were transferred from the antenatal/postnatal ward to work on the labour ward, leaving their own ward short of staff. Although the trust had an escalation policy, this was not always applied in practice.

The trust had a system to report and investigate incidents. Some of the staff said they did not always have time to report incidents, particularly about short-staffing, and the busier the department, the harder it was to find the time to do so. We saw evidence that lessons had been learned from incidents reported and that these were shared with staff.

Arrangements for assessing and responding to patient risk were not sufficient and there was a risk that patient safety needs may be overlooked because appropriate prompts were not included on all documents. We also noted that the time intervals for recording one patient's observations were not sufficiently frequent to ensure patient safety. Mandatory training levels were below the trust's target for all staff groups.

Safeguarding arrangements were in place, although improvements were needed for completion of documentation. Processes needed to improve for women with social service involvement who had delivered their baby and needed an extended stay on the ward.

Clinical records were clearly documented, although we noted that some standard proformas did not contain all required information and that some records were not securely stored.

Incidents

- The trust reported a total of 490 maternity incidents and 89 gynaecology incidents between August 2014 and January 2015.
- Between November 2013 and October 2014 two serious incidents requiring investigation had been reported for maternity.
- The service managers informed us that all staff had access to the electronic reporting system and reported incidents regularly.
- The majority of staff informed us that they felt they did not always have time to report incidents, especially if they were busy. They told us that, if the incident was serious or had resulted in a negative outcome for a woman or her baby, they would report this. They would not report shortages of staff as an incident.
- We reviewed the root cause analysis reports for three serious incidents. We saw that each analysis provided a detailed account of the event, the outcome and the root cause of the incident.
- Action plans were in place for each of the reports we reviewed, including details of the objective, actions required, start date, person responsible, and an update on progress made. However, we noted that there was no expected completion date for the agreed action and that the progress column did not always include dates, making it impossible to determine when action should or had been completed.
- Staff told us that they received feedback on lessons learned from incidents through daily verbal updates. A summary of lessons learned was also recorded in the ward's communication book which staff were required to sign as evidence they had received the update. Updates were also included in the monthly newsletters which were circulated to all staff.
- We reviewed a sample of perinatal mortality meeting minutes and saw that there was good evidence of discussion around the cases presented at the meetings.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harms and harm-free care. We saw that the trust's achievement against the NHS Safety Thermometer was positive. Each ward area assessed itself against the number of indicators including patient falls, pressure ulcers and catheter-related urinary tract infections.

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- Information was displayed on the noticeboards in the ward areas, although not in a meaningful way that the public could understand. For example, dates for the reporting period were not clear and information was written using clinical terminology.

Cleanliness, infection control and hygiene

- Every ward and department we visited was visibly clean.
- Staff regularly washed their hands and used hand gel between attending to patients. The hospital's 'bare below the elbow' policy for best hygiene practice was adhered to.
- All areas of maternity and gynaecology had achieved a high level of compliance with the monthly Saving Lives audit. This infection control audit looked at compliance with staff being 'bare below the elbows', microbial decontamination, as well as insertion and on-going care of urinary catheters.
- There had been no reported cases of methicillin-resistant staphylococcus aureus (MRSA) or methicillin-sensitive staphylococcus aureus (MSSA) for 2014/15.

Environment and equipment

- Staff said they had access to most of the equipment needed to meet the needs of women and babies. However, we were told that there were shortages of thermometers and blood pressure monitors and that searching for these items resulted in delays in giving care. We were also told that the maternity department did not have its own oxygen saturation monitor for new-borns. This meant that babies who required their oxygen saturation levels recorded had to be taken to the neonatal unit. This impacted on the care for new-borns and could adversely affect their outcomes.
- We reviewed the resuscitation equipment and found that it was all present and in date. Most of the equipment had been checked daily, however, we observed that some of the resuscitaires on the labour ward had not been regularly checked daily and that some showed long gaps with a number of consecutive days where no checks had been made.
- Access to each area of the maternity and gynaecology wards was restricted via use of an intercom which required a member of staff to release the door to allow personnel to enter or exit the wards. However, we observed that the exit button for the antenatal/postnatal ward was positioned directly next to a fire

door release button, which did not have a plastic cover on it. This meant that patients or visitors who pressed the fire door release button could exit the ward without staff making necessary checks. We saw this happen on a number of occasions during the inspection.

- We observed that the antenatal clinic building required attention. For example, there were several areas with loose plaster. Some of these had been covered with posters. We saw that detailed plans of work required had been documented but there was no indication of when improvements would take place.

Medicines

- We observed that medication was stored and recorded as administered appropriately, including requirements for controlled drugs.
- We were told that there could be delays in discharging women because they were waiting for medication. The department had a dedicated pharmacist who visited each of the inpatient wards twice per week. On the days the pharmacist was present, there were no delays because the pharmacist was able to dispense medications immediately. However, when the pharmacist was not available, staff had to take prescriptions to the pharmacy which could take a number of hours to process.

Records

- We observed that the majority of patient records were stored securely, although we did see some records stored in trolleys on the ward which were not locked.
- The staff and women we spoke with informed us that all women were issued with a copy of their care plan which they retained and took to appointments throughout their pregnancy.
- We reviewed a sample of patient records in obstetrics and gynaecology and found that they had mostly been completed with relevant clinical information and signed and dated in accordance with guidelines. However, we saw that some patient records lacked detail and some information was recorded in retrospect. For example, details around the 'fresh eyes' approach requiring two members of staff to review foetal heart tracings was often recorded as 'fresh eyes done' but there was no description of the findings. Some of the staff explained that this happened because they were extremely busy and caring for more than one woman at a time.

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- We were also told that there were issues with IT because the community midwives used a different system to the main hospital. This meant that there was a lot of duplication in transferring information, which also increased the risk of error. Although this was a known problem, this was not recorded as a risk on the department's risk register.

Safeguarding

- The trust had a full-time, named midwife for safeguarding. The role was currently filled by a midwife on secondment to cover a period of extended sickness.
- Midwives and medical staff were expected to attend level 3 safeguarding training. Nursing and support staff were also expected to complete safeguarding training, although the level varied depending on their specific role. However, training uptake was poor for all staff groups and well below the trust's target of 90%. Completion for support workers was less than 40%. Completion for nursing and midwifery was 100% for level 2 training, but this fell significantly to 12.5% for level 3 training which is a requirement for all midwives. Medical staff had a completion rate of 33% for level 3 training.
- We were told that safeguarding concerns were assessed initially by the community midwife and that information was also gathered from women's GPs.
- Social vulnerability was risk-assessed during booking. There was an expectation that this risk assessment was repeated during pregnancy, but we found this did not always take place.
- Safeguarding referrals were also made by hospital-based staff and we saw evidence of this. From a review of a sample of files where safeguarding concerns had been identified, we saw that notes were very detailed. However, it was not always easy to establish what the significant points were, which might be crucial in an emergency.
- Arrangements were in place for care of teenage girls and women with substance misuse problems.
- Midwives routinely attended child protection conferences and prepared reports as necessary.
- There were arrangements for discussing safeguarding concerns at a multi-agency forum. We found there were times when women and their babies stayed on the postnatal ward for long periods of time while decisions were made about their future. We observed one woman who had been cared for on the postnatal ward for more

than two weeks, even though she was medically fit for discharge. We brought this to the attention of the senior leaders in the trust during the inspection. Immediate action was taken to work with other partner organisations to address this. Following our inspection we were told that a pre-birth protocol was being developed and incidences of delay have reduced.

Mandatory training

- We saw that completion of mandatory and statutory training was below the trust's target for all staff groups. For example, around 40% of staff in the directorate had completed conflict resolution training, less than 1% had completed dementia training. Training for fire safety and information governance were better attended at 70% and 76% respectively.
- Staff told us that they were not always given dedicated time to complete training sessions. For example, online training was expected to be completed during 'quiet' periods on a shift. But most of the staff told us that they rarely had the opportunity to complete training during a shift, and that one of the online training courses on immunisation took around eight hours to complete. Staff told us that they either did not complete the training or they completed it in their own time which was unpaid. There was a book to record training completed in their own time, but staff said they were not paid or given time off in lieu, so they did not always record it. The senior leaders told us staff were given protected time and if they recorded their additional time to complete their training they would be given the time off in lieu.
- Maternal and neonatal resuscitation training varied. Between 80% and 100% of midwifery and medical staff had completed the training. All medical registrars had completed it. There were different levels of resuscitation training, depending on the role of the staff member. It was unclear from the evidence provided what level of resuscitation training staff had completed.
- Over 95% of nurses working within gynaecology had completed resuscitation training.

Assessing and responding to patient risk

- There were arrangements in place to monitor the deteriorating patient for both women and new-born babies. We reviewed a sample of records and saw that these were used appropriately. Although, we noted that the early warning system for babies did not include a

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new-born observation track and trigger chart and that the early warning system for women's observations did not have a space to record blood loss or checks on the condition of the mother's uterus. These prompts were recommended as best practice by the Centre for Maternal and Child Enquiries.

- We also identified that women who had suffered a large blood loss during labour were not monitored frequently enough and guidance in trust policy was not specific about how often observations should be carried out. On one set of notes, we saw that a woman who had suffered a large blood loss was being monitored every 15 minutes for the first 30 minutes, every 30 minutes for the first two hours with reduced frequency as time progressed. However, this was not in line with national guidance which dictates that these women should be monitored more frequently. The Royal College of Obstetricians and Gynaecologists guidelines on post partum haemorrhage (2011), state that for a major blood loss of over 1000mls, continuous monitoring of pulse, blood pressure and respiratory rate should take place. We raised concerns about this at the time of the inspection. In response, the trust sent a letter (on 27 February 2015) to the labour ward for the attention of all midwives, stating that there was a requirement to ensure that a midwife stayed with the woman in the immediate postoperative or postpartum haemorrhage phase in addition to completing observations in accordance with trust guidelines, and escalating any concerns to the labour suite coordinator, obstetrician and the anaesthetist. We were satisfied that the trust had taken action to address our concerns.

Midwifery staffing

- A Birthrate Plus assessment had been undertaken to determine the staffing needs of the department. Birthrate Plus is a tool used to assess the needs of women and the number of midwives required to ensure that women are cared for safely. The report dictated that a ratio of one midwife was needed for every 25 women who required maternity care. The trust currently had a ratio of one midwife to every 30 women. This ratio took into account sickness and absence but was less than the assessment deemed was necessary.
- The department's draft annual business plan for 2015/16 included a request to increase staffing numbers, although this had not yet been approved.

- Following a number of recruitment drives, the vacancy rate for band 6 midwives was 2.66 whole time equivalent (WTE) posts, and 1.16 WTE healthcare assistants. There were no vacant midwifery band fivesix or seven posts.
- Sickness rates for nursing and midwifery staff and support workers were high and in November 2014 were 7% and 11% respectively. Sickness and attendance was being managed and rates for midwifery staff had fallen to less than 5% in January, February and March 2015.
- The majority of staff we spoke with throughout the service told us that they were short-staffed and that this impacted on the care they were able to give women because it was, "rushed."
- Community midwives told us that there were high levels of midwife vacancies in the community as well as high levels of sickness in some teams and, as a result, their caseloads were high. They told us that this meant they worked longer hours in order to see the women. Clinics overran, as did home visit lists. The midwives said they felt that women did not always understand the information given because there was insufficient time and care was rushed; this was more difficult if the women were unable to speak English.
- The antenatal clinic in the hospital was also short-staffed and this had been highlighted on the department's risk register. Staffing shortages were due to long-term absences as well as a number of midwives reaching retirement. We were told that cover was usually provided. One of the specialist midwives frequently provided cover on the department and this had improved the staffing levels.
- The labour ward had 15 rooms, with six midwives working each shift. The midwives we spoke with told us the department was very busy and that they often cared for more than one woman at a time. This frequently involved looking after one woman in established labour as well as another woman who may have recently delivered their baby or another who was in early stages of labour.
- An elective theatre list ran in the mornings, four days per week. During this time a dedicated theatre team was provided. After 1pm one of the labour ward midwives doubled as a theatre scrub nurse if there were any emergency caesareans. Cover was provided by a rota until 9pm when the out-of-hours theatre team took over. This meant that a midwife or healthcare assistant who could be caring for a labouring woman may be called in to provide assistance in theatre.

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- Because of the acuity of women, the department could be busy even if it was not full. The antenatal/postnatal ward could care for up to 24 women which were used flexibly to meet demand. Three midwives were allocated to each shift; one midwife to care for antenatal women and two midwives for postnatal women. In addition to this, a safeguarding midwife worked some daytime shifts and was responsible for dealing with all social issues a woman may have.
 - Midwives told us that, when all four midwives worked, the department ran smoothly, but they rarely saw the additional safeguarding midwife.
 - Midwives also told us that they were frequently 'pulled' from their ward to work on the labour ward. We reviewed the rota for a sample of 10 separate dates. We saw that, although it was reported that midwives had been fully staffed on each occasion, on six dates midwives or healthcare assistants had been moved to work on the labour ward and, most of the time, the midwife did not return for the duration of the shift.
 - During 2014 there were six occasions reported where the antenatal/postnatal ward had been staffed temporarily by only one midwife. Four of these occasions were in October 2014 (data provided was November 2013 to October 2014 inclusive).
 - There were 51 staffing-related incidents reported between August 2014 and mid-January 2015; 33 were recorded as labour ward and 16 as antenatal/postnatal ward incidents. Some of the labour ward incidents included issues related to staffing on the antenatal/postnatal ward, but these had not been reported separately and, therefore, an accurate reflection of the incidents per ward could not be monitored. A small number of the incidents involved issues with community staffing, but only if this affected hospital staffing. There were no incidents reported by community midwives; this did not reflect the poor staffing arrangements in the community that we were told about.
 - The head of midwifery prepared a monthly staffing report for the governance committee. We were provided with a copy of the December 2014 report which indicated that there were eight shifts on the labour ward with a variance against the plan, and seven shifts on the antenatal/postnatal ward that had been over-establishment but no reports of understaffing.
- From the staffing incidents reported for December, we saw that midwives had been moved from the ward to facilitate need on the labour ward on three separate occasions.
- One-to-one care in labour was not reported on the maternity performance dashboard. We were told by most of the midwives that it was not always possible to provide women with one-to-one care in labour because they were often looking after more than one woman at the same time. They told us that sometimes they needed to care for up to three women at the same time, although, they would not be expected to look after more than one woman in active labour.
 - We were provided with a staffing report for December 2014 which indicated that women were given one-to-one care in labour 100% of the time. We asked the managers of the service how this figure was established and were told that this was based on the National Maternity Safety Thermometer where post natal women were asked on one day each month if they were worried or left alone in labour. The midwife in charge also reported on the number of women in established labour (although the latter does not factor in the number of women on the labour ward). We were told that an audit had not been undertaken on one-to-one care provided to women in established labour. The Safer Childbirth Guidance 2007 states, "Maternity services should develop the capacity for every woman to have a designated midwife to provide care for her when in established labour for 100% of the time". This concept is also supported by National Institute for Health and Care Excellence (NICE) guidance. We noted that one of the staffing incidents for December 2014 reported that, on one occasion, they were unable to provide all women with one-to-one care as required.
 - Midwives in all areas of the department told us that they often did not get time for a break and that they worked for an extra hour or so after their shift had ended because they needed to complete paperwork. The majority of midwives worked 12-hour shifts. The senior leaders in the trust told us if they recorded their extra hours worked they would be remunerated accordingly.
 - Handovers took place at the beginning of each shift. The lead midwives attended, along with all midwives due to start the next shift. We observed a handover which we found to be ineffective because it was difficult to hear the information being shared with the oncoming team.

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This was because the midwife conducting the handover had her back turned to staff and was facing the noticeboard while speaking, and also because one midwife held a telephone conversation throughout the handover.

- Individual patient handovers also took place, which we found to be effective.

Gynaecology staffing

- There was a vacancy of 0.89 WTE for band 6 nurses in gynaecology. We were told that staffing arrangements worked well and that cover could usually be provided if required. This was supported from our review of the rotas.

Medical staffing

- There was adequate medical staffing for obstetrics and gynaecology and the number of hours of consultant cover provided met minimum requirements. Locum cover was arranged as necessary to cover shifts. There was one WTE vacancy for a consultant post in gynaecology and one WTE vacancy for a registrar within obstetrics and these were being recruited to. Sickness rates were very low at 0.2% in November 2014.
- We were told that consultant on-call arrangements worked well and the staff told us that they were always able to get hold of a consultant if they needed to.
- There was good access to an anaesthetist and one was usually available unless they were involved with an emergency. This was not the case for paediatricians. We were told that the paediatricians completed their rounds in the morning, which worked well. However, babies who were ready for discharge in the afternoon or early evening and required an assessment from the paediatrician had to wait a long time to be assessed.
- We observed a ward round and saw that patient information discussed was appropriate and the process was effective.

Escalation arrangements

- The trust had an escalation policy which outlined minimum staffing levels. We were told that the trust had never “closed its doors” for maternity although, the unit had closed on two occasions during 2013. Some of the staff told us that they thought there were occasions when it would have been safer to do so.
- We requested data on the number of times the service had implemented the escalation policy. We were

provided with details of 50 staffing incidents that had occurred between January and December 2014. However, it was not always apparent from the detail recorded whether the escalation policy had been implemented or not in response to staffing shortages. We also saw some examples where there were staff shortages and cover had not been found.

- There was no evidence whether the maternity escalation policy had been implemented due to the volume of women attending the department, as opposed to minimum staffing levels not being met.

Are maternity and gynaecology services effective?

Requires improvement 

The effectiveness of the maternity and gynaecology service required improvement.

There were arrangements in place to audit the care and services provided. While it was identified through audit that some standards had improved, others had not and were still poor compared to the England averages.

Outcomes for women were variable. There was a high rate of births being induced and, of those, a significantly higher rate of emergency caesareans than the England average. The perineal tear rate fluctuated and was very high some months, with no consistent downward trend. We saw that some midwives were responsible for providing care for women recovering from surgery, but they had not received an adequate level of training to do so. There was a lack of midwives trained to perform basic tasks, for example suturing and cannulation as well as new-born baby checks. This impacted on the patient flow in the department as reliance was on a limited pool of staff.

We saw that women received pain relief as required and adequate arrangements were in place to ensure women and their babies received nutrition and hydration. Seven-day services and multidisciplinary team working was good and staff had an understanding of the Mental Capacity Act 2005.

Evidence-based care and treatment

- There was a trust-wide clinical effectiveness committee that received updates on audits and impending

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guidance. For example, guidance from NICE or the Royal College of Obstetricians and Gynaecologists was presented and discussed at the committee, along with regular compliance reports. Minutes were shared with the divisional governance committees.

- We reviewed care pathways and patient records. From the samples we reviewed, most were compliant with the associated standards and local procedures. However, we saw some examples where local guidance and proformas were in need of updating.
- An obstetrics and gynaecology clinical audit plan was prepared annually. The 2014/15 audit plan listed a total of 43 audits which were proposed to commence during the year. The plan included local and national priorities. Start dates had been agreed and a lead assigned for all but four of the audits. However, we were not provided with a progress update and therefore it was not possible to determine whether all audits had been commenced or completed.
- We were provided with a copy of the recommendations from the Caesarean Section Audit which included a review of completion of the World Health Organization (WHO) surgical safety checklist. We requested a copy of the full audit, but this was not provided, therefore it was not possible to determine whether the aims and objectives were clear and had been followed. One of the recommendations was to improve completion of the WHO checklist as part of the 'five steps to safer surgery', but from the information provided the compliance rate was unclear.
- The acute gynaecology admissions consultant review audit set out clear aims and objectives and made comparisons with audits undertaken in previous years. It was evident that improvements had been made, although more work was needed. However, there were no clear recommendations or action plans. Recommendations from previous audits were included but they were not concise and it was not clear if they had been implemented or not.
- A postoperative care audit included details of its aims and objectives along with data gathered and reviewed which clearly demonstrated where improvements were needed. However, the audit information did not include recommendations or an action plan.
- An audit of incidents of 3rd and 4th degree perineal tears (perineal trauma) was undertaken in 2013 and an action plan developed. Most of the actions had been colour-coded as green as evidence of implementation,

however, we noted through review of the performance dashboard that although they had reduced during 2014, perineal traumas remained high. It was unclear how effective the recommendations from the audit had been.

- The audit on obstetric care of women with a body mass index (BMI) greater than 40 demonstrated that, since the previous audit, significant improvements had been made in the management and referral of women to specialist services. Recommendations had been made to make further improvements.
- It was difficult to determine whether the full audit cycle was embedded in practice to ensure that regular improvements were made.

Pain relief

- All of the patients and women we spoke with told us that they had received pain relief as required.
- Staff told us that there were no issues in obtaining pain relief or other medication for patients and women.

Nutrition and hydration

- Women were all satisfied with the support they received for breastfeeding their babies. Breastfeeding rates were recorded on the performance dashboard for October 2014 at 60%. A target of 66% had been set and performance was reported monthly on the performance dashboard. The trust had Stage two Baby Friendly Initiative accreditation.
- Ready-made formula bottles were also available for mothers who chose not to breastfeed their babies.

Patient outcomes

- The maternity department maintained a quality and performance dashboard that reported on activity and clinical outcomes.
- We were provided with a copy of the dashboard for November 2013 to October 2014. We observed that the instrumental delivery rate was in line with the national average. Unexpected admissions for babies to the neonatal unit and/or mothers to the high dependency unit (HDU) were generally in line with the trust's targets, although HDU admission rates had been exceeded on three occasions during the year.

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- Performance for other clinical outcomes varied from month to month, and some were consistently poor, for example, induction of labour was significantly higher than the national average for 10 out of 12 months.
- The elective caesarean section rate fluctuated each month, with seven months of the 12-month period within the national average range; the remainder of months exceeded the national average and there was no consistent downward trend.
- Caesarean sections performed following an induction of labour were significantly higher than the England average for 10 of the 12 months.
- The perineal tear rate for women who had given birth was also high most months, with some fluctuation. This improved from April 2014 for some delivery types, but not all. This had been audited and action taken, including additional training for staff.
- The number of women who had suffered a postpartum haemorrhage was very high for October and November 2014. In January 2015 there were three post partum haemorrhages. Prior to September 2014 the rate was low.
- Service managers told us that performance was worse than the England average for some targets because of the clinical complexity of women attending the unit. For example, the number of women with diabetes or with a high BMI was reportedly higher than the national average.
- The management dashboard for gynaecology reported positive outcomes for inpatients and outpatients receiving their first definitive treatment for the year to date as at October 2014. The gynaecology department were also achieving all targets for seeing patients with suspected cancer within agreed timescales. The average length of stay on the ward was lower than the target which was positive; however, we observed that the readmission rate for elective patients was significantly higher than expected. Readmissions were recorded on the performance dashboard and monitored through governance meetings. Cases were retrospectively audited to identify common themes and learning. We also noted that the average bed wait was significantly higher than expected and the number of cancelled operations was also higher than the agreed target.
- The staff we spoke with all told us that they had received their annual appraisal and that they found this process helpful. We saw that, as at November 2014, 87% of nursing, midwifery and support assistants had received their annual appraisal.
- To ensure that all midwives had their competencies maintained and up to date, the trust reviewed and revised its 'rotation' arrangements for midwives. Plans were being developed to structure a rotation for all staff, in particular to provide skills for community midwives and to ensure there was adequate cover across all areas of the maternity department. We were told that some of the community midwives who assisted the labour ward and antenatal/postnatal ward did not have the required skills, which meant they did not carry out the full duties expected of a midwife. This placed additional pressure on the midwives who worked permanently in the unit. For example, we were told that some community midwives would not give out medication on the antenatal/postnatal ward.
- We were told that there were not enough mentors to sign-off the student midwives' development plans. Student midwives had mixed opinions about how well they were supported.
- We were told that not all midwives were able to cannulate (put a needle into a vein) or suture (stitch), which placed additional pressures on the midwives who were able to.
- Midwives were not trained to provide recovery care for women postoperatively but were required to perform this role. A risk assessment had been undertaken and some mitigating actions put in place, such as presence of an anaesthetist and operating department practitioner during normal working hours. Further action was planned, for example, having trained recovery staff available 24 hours a day. There were no timescales for this action. The head of midwifery told us that there was no HDU training programme in place at present but that this was being revisited as part of the training needs analysis.
- The maternity unit had 14 midwives (this included four community midwives) trained to undertake the New-born and Infant Physical Examination. All babies are required to have this check within 72 hours of delivery. These checks are usually performed before the baby is discharged, although can be carried out after discharge by a paediatrician, a junior doctor or midwife who has completed the required training. Staff told us

Competent staff

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and we saw that a significant number of babies were being discharged and needed to re-attend the unit to receive their New-born and Infant Physical Examination. However data we received from the trust did not reflect this and suggested only 2% of babies were required to re-attend following early transfer home.

Multidisciplinary working

- Staff reported good multidisciplinary team working, both internally and externally. Staff reported that medical and nursing/midwifery staff worked well together and that the team handovers, which took place twice-daily, worked well. Although we noted that the full complement of staff with a specialist interest in mental health issues were not present, a care pathway was in place.
- We were told that external arrangements also worked well and that there were good communications and links with local GPs as well as social services. Information was regularly received from social services regarding individuals, specifying any support they may be receiving or may need. However, we noted that working arrangements with health visitors did not always work well and there were no joint visiting arrangements between health visitors and midwives.

Seven-day services

- Out-of-hours services were available in emergencies. All women could report to the hospital in an emergency either via A&E or maternity reception. The maternity unit had scanners available which could be used out of hours if necessary. During the day an early pregnancy assessment unit and day assessment unit available. Guidance on self-referral or GP referral was provided at a woman's first appointment.
- There was a dedicated obstetric theatre used for elective caesarean sections during the agreed timeslots and for emergencies outside of these hours. The maternity department also had access to main theatres 24 hours per day for emergencies.
- We were told that the pharmacy service was available out of hours using the on-call system if necessary.
- Consultant cover was provided for 62.5 hours per week and on-call arrangements were in place.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Arrangements were in place to seek consent for surgery for all aspects of obstetrics and gynaecology. We reviewed a sample of patient notes and found that consent forms had been signed where it was appropriate to do so. However, we observed that this did not always happen. We saw one woman who was unable to speak English fluently being asked to consent to treatment; her husband interpreted the information for her and her response to staff. It was not clear that she had understood the question.
- The trust had set procedures for assessing someone's capacity through the emergency and elective route. We were told that medical staff had responsibility for assessing a patient's capacity. Staff we spoke with talked confidently about mental capacity assessments within the remit of their role.

Are maternity and gynaecology services caring?

Good



The caring afforded to women was good.

The women and relatives we spoke with all reported that they received a good standard of care from all members of staff. Women told us that staff were busy but caring and that information had been explained to them about their treatment.

Compassionate care

- Women and their relatives all reported that they received a good standard of care from all members of staff.
- Feedback in the Survey of Women's Experience of Maternity Care (CQC 2013) reported positive findings overall for each aspect of maternity care provided; findings were similar to the England average.
- Feedback from the NHS Friends and Family Test for maternity services was positive. For December 2014 and January 2015 there was a higher-than-the-England-average response rate and all respondents reported that they were likely or very likely to recommend the service to their friends and family.

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- Data for the gynaecology ward was less positive, with 38% of women reporting they would recommend the service in November 2014 and 64% in December 2014. Responses fluctuated throughout the year.

Understanding and involvement of patients and those close to them

- The women we spoke with all reported that communication was good throughout their pregnancy and that their partners had been involved. Visiting arrangements were in place for relatives, with extended stay arrangements for partners antenatally and postnatally.

Emotional support

- The trust had a bereavement midwife who was responsible for speaking with women and their families who may have been bereaved during or after childbirth, or who required a termination due to medical reasons. The midwife offered support and advice to women and their families at specific stages but was also contactable if needed. Information detailing various agencies that provide counselling support for women and their families was also provided.

Are maternity and gynaecology services responsive?

Requires improvement 

The responsiveness of the maternity and gynaecology services required improvement, although responsiveness was good within the gynaecology part of the service.

We saw, and were told, that the maternity department was often very busy and that staff did not always have time to provide individualised care. The acuity of women was high and there was a high number of women with social needs who delivered their baby at the hospital. This meant that more time needed to be dedicated to a significant proportion of the women.

Also, women returned to the department with their babies for checks which could have been performed earlier or in the community setting if there were sufficient numbers of midwives trained to do so. Babies also reattended if they had suspected jaundice, something which in other hospitals is typically assessed and treated by the neonatal

unit. Some women remained in the antenatal ward for longer than they should because the labour ward was too busy. All of these factors impacted on the access and flow within the department.

There were translation services available for women who did not speak English, although these did not always work as planned and there were a lack of information leaflets in other languages.

There was evidence of learning from complaints.

Service planning and delivery to meet the needs of local people

- Business plans for 2015/16 had been developed for obstetrics and gynaecology as well as sexual health services, and were due to be approved. Cost pressures had been identified and bids placed for recurrent and non-recurrent funding. Some areas required a business case proposal. It was noted that the issues we identified during the inspection – such as around access and patient flow and meeting individual needs – had not been factored in to the service planning and delivery.
- An estates plan had been developed to: relocate the integrated sexual health services; upgrade the procedure suite within gynaecology; relocate the onsite antenatal clinic to include additional facilities. Work was expected to be completed by the end of 2017.

Access and flow

- We observed that the gynaecology ward was well-run and the staff told us that the patient flow worked well.
- The percentage of women accessing maternity services within the first 12 weeks was just over (better than) the trusts own target.
- Women who attended the unit, including because they suspected they were in labour or had reduced foetal movement, were assessed by the triage midwife. All women attending the unit with reduced foetal movement were expected to be assessed by the triage midwife within 20 minutes of arrival. An audit of women attending with reduced foetal movement was being undertaken. Initial data showed the 20-minute target was being met in the majority of cases.
- We were told that any gaps were because of short-staffing as well as the acuity of the women the midwives cared for. We were told that the number of women whose acuity was intermediate was 40%

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compared to the national average of 25% which meant that these women had higher needs than low-risk women, and this meant more time was spent caring for them.

- We also observed that work streams impacted on the access and flow in to the department. Some women were on the labour ward who could have been cared in another area of the maternity department. For example, we saw one woman who suffered a blood loss and remained on the labour ward for 24 hours when she could have been transferred to the postnatal ward to be cared for. Other women were on labour ward waiting to be induced while staff were extremely busy caring for other women.
- There was a high number of women who returned with their babies following discharge, either for 72-hour New-born and Infant Physical Examination check or because the baby had suspected jaundice. It is best practice for babies readmitted with jaundice to go to the special care baby unit to minimise the risk of infection for new-born babies on the postnatal ward. The babies were reviewed in a dedicated paediatric facility on the post-natal ward. The trust told us their jaundice admission rates were significantly below national average; there were high numbers attending but low numbers re-admitted. Following our inspection the trust told us they had acquired point of care equipment for jaundice so the service could be delivered in the community. Both of these factors were impacting on the flow within the postnatal area of the ward because women and babies were attending the department or being admitted unnecessarily. During a seven-day period in February, we observed that seven babies returned to the department for their new-born and Infant physical examination, eight babies returned because of suspected jaundice and five babies returned for other reasons.
- We were also told that there was a high number of women who remained in the unit for long periods for 'social services reasons'. During our inspection, one woman had been on the post natal ward for over two weeks. However, no data was collected to support the midwives' perception. Following our inspection we were told data to determine length of stay for social care reasons had been collected since September 2014 and was routinely reported to the Family Health Governance meeting.

- Midwives told us that women were waiting on the antenatal ward for a bed on the labour ward longer than they should because all of the rooms were full. They said that sometimes women had their babies on the antenatal ward, either because the labour ward was full or because the baby was delivered quickly. Data we were provided with indicated that this had occurred on four occasions per month during August, September and October 2014. There was no data reporting that births had occurred in antenatal ward since October 2014.

Meeting people's individual needs

- We were told that women who used the service who were unable to speak English fluently could access an interpreter service if required. An interpreter could be booked to attend antenatal appointments if necessary, and a telephone service was also available. The staff we spoke with reported that this worked well on occasions, but not all of the time. Sometimes interpreters were booked but women did not attend and therefore arrangements were not made consistently. Some of the midwives we spoke with told us that they did not always feel that women had understood the information conveyed to them. We were told that relatives were sometimes used to help interpret information and we observed one example of this happening. This meant there was a risk that women were unable to talk to staff without their family being involved and it is not good practice.
- We were told that there were information leaflets available in other languages and formats, however, these were available on an ad-hoc basis and information was not consistently available for all topics. This meant that not all women were able to receive information about the care they could expect or any aftercare arrangements.
- Staff told us that, if a patient who used the service had any specific needs, whether these were mental health, social or safeguarding needs, they would contact the midwife or trust safeguarding lead or refer to guidance on the intranet for advice.
- We saw that the early pregnancy assessment unit was located next to the pregnancy advisory service. This was being managed as sensitively as it could be by staff, for example, there were separate waiting areas for patients. There were plans to separate the two areas in 2016.

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Learning from complaints and concerns

- Leaflets were available that explained to patients how to make a complaint, including the necessary contact details.
- Between November 2013 and October 2014, a total of 37 complaints had been received. Systems were in place to respond to and monitor complaints. It was not possible to determine whether all complaints had been dealt with in a timely manner because a number of the complaints which had been closed did not record the date they were closed.
- Communication issues were a common theme of complaints. Complaints had also been received about the location of the early pregnancy assessment unit, situated next to the pregnancy advisory service. Plans were in place to separate the two areas, although work would not be completed until 2016.
- Staff received feedback about complaints via the staff newsletter as well as handover briefings.

Are maternity and gynaecology services well-led?

Requires improvement 

The leadership of the maternity and gynaecology service required improvement.

The maternity service had a documented strategy, although this was not the case for gynaecology and there were no clear timescales to ensure the operational plan was delivered.

There was a clear governance structure in place, although action plans could be clearer to ensure these were followed up. The accuracy of discussion around performance could be improved to ensure it reflected the performance being achieved and any actions agreed and documented.

Staffing arrangements and escalation processes within maternity were not always well-managed and workstreams were not effective which impacted on the patient flow within the department.

There were clearly defined accountability arrangements and staff felt well-supported by their immediate line manager, although some commented that they rarely saw senior managers on the wards or in the community.

Vision and strategy for this service

- The maternity department had a strategy which set out its vision. There were four key objectives which were to: deliver quality standards and reduce harm as well as improving outcomes for women and their babies; deliver the workforce plan; improve its financial position; and improve marketing and communication. This was underpinned by an operational plan which stated how the objectives would be met. Although, it was noted that the agreed actions did not have a clear timescale and had not been assigned to a lead responsible for implementation.
- The integrated sexual health service had set objectives but no documentation on how these objectives would be measured or monitored. There were no clearly defined objectives for gynaecology.

Governance, risk management and quality measurement

- There was a family health governance and assurance group which was attended by key individuals within the directorate and reported to by the risk and governance committee for maternity and risk and governance committee for gynaecology and sexual health. A risk and validation committee had also been recently established.
- The family health governance and assurance group received regular reports, for example, on complaints, incidents and performance and we saw evidence of discussion around these issues. However, actions agreed were not clearly defined and therefore could be overlooked for ensuring action had been taken. The group's January 2015 meeting indicated that the maternity dashboard showed no issues. However, from our observation of the dashboard it was evident that there was underperformance for a number of targets.
- A risk register was maintained which detailed all risks identified by the committee. A risk assessment form was completed for all new and emerging risks. This was discussed by the committee and a decision was made about whether the risk should be added to the register. Each risk on the register was clearly defined, scored and recorded the controls were in place. However,

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ownership of the risk, along with further action required, were not documented. The review date for each risk was recorded and it was noted that some were overdue. It was also unclear how long the risks had been on the register or when they had been reviewed.

- We identified some issues during our inspection which were not on the risk register, for example, staffing issues on antenatal/postnatal ward as well as on the labour ward.

Leadership of service

- The department had a clearly defined accountability structure. The directorate of family health had a director of clinical services, directorate general manager and directorate head of midwifery/nursing/professions. The leads were supported by their deputies and ward or department managers who reported to the deputies.
- Staffing arrangements and escalation processes within maternity were not always well-managed and workstreams were not effective. This had an impact on the patient flow within the department.

Culture within the service







- The staff we spoke with all reported that they felt very supported by their immediate line management and that they had good working relationships with all staffing groups. However, some staff said they rarely saw other senior management from the department.

- Staff told us they felt confident that, if they needed to report serious concerns, they could do so by following the trust's whistleblowing policy and they would be listened to.

Public and staff engagement

- Staff had the opportunity to provide feedback at daily handover meetings and at monthly team meetings. Some staff told us that they did not always have time to attend the team meetings.
- Student midwives were offered the opportunity to provide feedback to the head of midwifery's 'air and share' meetings which were held each month. We saw evidence of action notes taken.
- Feedback in the Survey of Women's Experience of Maternity Care (CQC 2013) reported positive findings overall for each aspect of maternity care provided; findings were similar to the England average.
- Feedback from the NHS Friends and Family Test for maternity services was positive. For December 2014 and January 2015 there was a higher-than-the-England average response rate, and all respondents reported that they were likely or very likely to recommend the service to their friends and family.
- Data for the gynaecology ward was less positive, with 38% of women reporting that they would recommend the service in November 2014 and 64% in December 2014. Responses had fluctuated throughout the year.

Services for children and young people

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

Information about the service

The children's services were provided on a special care baby unit (SCBU), seven-bed/cot children's assessment unit, a 24-bed/cot children's ward and children's outpatients unit. The SCBU provided two intensive care (level 3) cots, two high dependency (level 2) cots and 10 special care cots.

There had been 2,901 clinical patients seen with the paediatrics speciality in 2013/14 and the vast majority (98%) were emergency admissions.

We visited all clinical areas that provided care to children. We spoke with 37 staff, 14 parents and children, and we looked at 11 sets of patients' notes.

Summary of findings

Overall we judged the services for children and young people as inadequate.

We found a number of environmental safety concerns, particularly for patients with mental health needs cared for on the children's ward. We raised concerns at the time of inspection and the trust took immediate action to mitigate some of the risks.

The staffing establishment fell below nationally recognised guidelines on the children's assessment unit, on the children's ward and SCBU. Concerns were raised at the time of our inspection and the trust took immediate action to improve staffing levels.

There was a concern that patients could be at risk because safety concerns were not identified or dealt with appropriately and in a timely manner. The approach to safety was inconsistent and learning was not shared widely. Compliance with mandatory training was 66% or below.

There were appropriate systems for safeguarding and staff understood their responsibilities for reporting safeguarding concerns externally. However, reporting of safeguarding internally was less robust and not all staff had received training.

Services for children and young people

Children and young people's needs were assessed and care and treatment delivered in line with current legislation. There was limited evidence to show that clinical interventions resulted in positive patient outcomes.

Staff were not always supported to participate in the training and development that would enable them to deliver good quality care. Staff had not had training on the Mental Capacity Act 2005 or training to enable them to provide support and care to children who had mental health needs. We raised these concerns with the executive leaders in the trust during our inspection. At the unannounced inspection, training had been arranged for Child and Adolescent Mental Health Services (CAMHS) awareness for all staff to attend.

Staff did not participate in clinical supervision and did not have regular meetings with their managers.

Generally staff treated children, young people and their families with compassion, kindness, dignity and respect. Staff built positive relationships with children, young people and their families. However, services were not always delivered in a way that met the needs of all children and young people, such as children who had mental health concerns. The approach to meeting the needs of different groups could be reactive. The hospital had no formal adolescent transitional arrangements for all pathways to facilitate transfers between child and adult services.

The vision and values for the service were not well-developed or established. Governance arrangements were unclear and provided limited assurance in identifying and managing risks and concerns. There was a limited approach to the management of risk and it was unclear who was responsible for reviewing and managing identified risks. The trust did not have access to a senior children's nurse at all times.

Are services for children and young people safe?

Inadequate 

The safety of the service was inadequate.

We found a number of environmental safety concerns, particularly for some of the patients on the children's ward with mental health needs. The ward staff were not trained or experienced in meeting the needs of children and young people with mental health needs. We raised concerns at the time of inspection and the trust took immediate action to mitigate some of the risks.

The staffing establishment fell below nationally recognised guidelines on the children's assessment unit, on the children's ward and SCBU. Concerns were raised at the time of our inspection and the trust took immediate action to improve staffing levels.

There was a concern that patients could be at risk because safety concerns were not identified or dealt with appropriately and in a timely manner. The approach to safety was inconsistent and information about safety was not comprehensive and learning was not shared widely.

Compliance with mandatory training showed between 43% and 66% compliance. There were appropriate systems for safeguarding and staff understood their responsibilities for reporting safeguarding concerns externally. However, reporting of safeguarding internally was less robust and not all staff had received training.

There were appropriate systems to protect children and young people against the risks associated with the unsafe use and management of medicines.

Incidents

- The trust used an online system to report incidents. Senior managers felt that staff were good at reporting incidents. There had been 111 incidents reported between August and November 2014 in children and young people's acute services. There were no serious incidents requiring investigation for acute children's services during this time period.
- The majority of reported incidents related to medication. A pharmacist reviewed medication every day on the paediatric wards and completed incident

Services for children and young people

forms for medicine errors. The Pharmacist provided staff with a weekly review and learning log for medication incidents reported that week. These were shared through the governance arrangements.'

- When things went wrong, the approach to reviewing and investigating causes was insufficient or too slow. Incidents were not always investigated in a timely manner and actions were not always identified and implemented. We were told about a significant incident relating to a patient at risk of self-harm in September 2014. Staff did not know what action, if any, the trust had taken to reduce the risk of a similar incident happening in the future.
- We spoke with staff about incident reporting. Staff told us they did not routinely report near misses. Near misses are incidents that happen that did not result in injury, illness, or damage but had the potential to do so. There was little evidence of effective learning from incidents and any lessons learned were not always identified to improve safety within service.
- We found evidence of reporting and learning from incidents on the SCBU. For example, staff on this unit told us about learning from an incident which had resulted in a change in practice for the prescribing of the antibiotic Gentamicin.
- Staff told us they did not always receive feedback on incident reports. Staff did not know what the main themes of incidents and risks within the paediatric directorate were.
- We asked the trust to send us incident reports and action plans for six incidents reported between August 2014 and January 2015. We received summaries of the incidents and were unable to see evidence of learning for staff and any changes or improvements in service provision following the investigation.

Cleanliness, infection control and hygiene

- Infection control procedures were in place on the wards we visited and the wards were clean at the time of our inspection. Hand gels were available at the entrance to the wards with instructions for their use to reduce the risk of infection.
- Personal protective equipment was available on the ward.
- The ward and shower areas were clean, although the wall within one bathroom appeared to be in a state of disrepair with a taped area of cardboard. The area had

no attached notification of the issues or any evidence that this had been reported to the estates team. Staff were notified at the time of the inspection but were unaware of the reason for the cardboard.

- There were no reported cases of methicillin-resistant staphylococcus aureus (MRSA) or Clostridium difficile (C. difficile) on the paediatric wards.
- The last infection control audit was completed in August 2014 and this showed high levels of compliance.

Environment and equipment

- We found a number of environmental safety concerns on the children's ward. We raised concerns with the trust at the time of our inspection so they could take immediate action.
- The Health and Safety Executive (2004) directs trusts and directorates responsible for caring for patients who may exhibit self-harm behaviour to reduce possible risks associated with potential ligatures and anchor points.
- We found many ligature and anchor points on the paediatric ward yet no risk assessment had been completed. For example, there were doors whose closing mechanisms could be an anchor point. There was cotton tape stored in the corridor on top of the suction trolley opposite a nurse's station which could have been used as a ligature. The tape was removed at the time of our inspection.
- Staff told us, and our observations confirmed, that they were children on the ward who had mental health needs and had been admitted because of self-harm. At the time of our inspection, there were children on the ward who were at risk. The trust responded to our concerns and provided one-to-one care for all children awaiting an assessment by CAMHS, except in cases where a consultant had signed a risk assessment to indicate that this was not required.
- We asked the trust to complete a ligature risk assessment and show it to us. The trust completed an assessment of the self-harm risks on the children's wards and identified actions to ensure the safety of children on the wards.
- The ward was large and was formed of three wards combined in to one. The layout of the ward did not facilitate the clear observation of children and young people.
- During our inspection we found that a door leading on to a stairwell was unlocked. Although the door was alarmed, the alarm could not be heard throughout the

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ward. We opened the door and it was several minutes before any member of staff came to enquire why the door had been opened. This was a serious risk of potential harm to a child. We raised our concerns at the time of the inspection and the trust took immediate action to secure the door.

- Resuscitation equipment was available and checked daily.

Medicines

- The Pharmacist provided staff with a weekly review and learning log for medication incidents reported that week. These were shared through the governance arrangements. There was a dedicated pharmacist for the children's services. Staff told us this role supported appropriate prescribing and administration.
- There was an audit programme across children and young people's services including drug omission, medicine security, storage of medicines and antimicrobial prescribing.
- There were appropriate systems to protect children and young people against the risks associated with the unsafe use and management of medicines. Systems were in place to identify learning from incidents and near misses relating to medicines so that the risk of recurrence was reduced.

Records

- The trust had introduced an electronic patient record, however, there had been issues with the implementation and, therefore, the majority of records were still paper-based. Discharge letters and test results were available on the electronic records and staff found the system was efficient and accessible.
- Records were kept on the wards and stored in secure cabinets. However, we found that cabinets were not locked and notes were left open and unattended at the nurses' stations.
- Records completed in the handover process were reviewed and included information that supported clinical prioritisation.

Safeguarding

- There was a trust-wide safeguarding policy in place.
- The named nurse for children's safeguarding was currently not at work and interim arrangements were in place. The trust put a number of actions in place to provide cover during the period of long term absence.

The senior management team were not able to assure us that succession plans were being put in place. The absence of several members of the safeguarding team was recorded on the Safeguarding Risk Register.

- 62% of staff had completed level 2 safeguarding training and 68% had completed level 3 safeguarding training.
- Staff working within the children and young peoples' directorate received level 3 safeguarding training within the trust's expected timespan of every three years. Due to vacancies in the children's safeguarding posts, there had been a lapse in mandatory level 3 safeguarding children training. The ward manager had a record of staff whose training had lapsed and details of staff booked on to the next available training.
- No safeguarding supervision was available for ward staff.
- We found that staff reported safeguarding concerns appropriately to external agencies for investigation. However, staff were unclear about the process for reporting safeguarding concerns internally within the trust.

Mandatory training

- Records provided by the trust showed between 43% and 66%... 'Between 43% and 66% of all staff providing children's services on the children's ward had completed moving and handling training.
- 61% of all staff providing children's services on the children's ward had completed resuscitation training. This meant there was a risk that staff working on the ward were not competent to undertake resuscitation if needed.

Assessing and responding to patient risk

- The children's service used the Paediatric Early Warning Score (PEWS) system which helped staff to identify children who were becoming poorly so they could be promptly transferred to a regional centre when required.
- Staff had completed pressure ulcer risk assessments.
- Children and young people up to the age of 17 with mental health needs who presented at the hospital's A&E could be admitted to the paediatric ward until they were offered a place in a specialist unit or discharged home. We found recent cases where young people had to stay on the ward for three to four weeks. We raised

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our concerns that there were no care plans for to specifically address mental health needs. The trust contacted the mental health trust that provided this service to review the arrangements.

- The paediatric ward staff worked hard to provide appropriate care but were not trained or experienced in meeting the needs of children and young people with mental health needs. Staff had not received training and did not demonstrate an understanding in managing the specialist risks associated with caring for these young patients. We raised this concern at the time of the inspection. At our unannounced inspection, we saw that the local mental health trust was scheduled to provide initial training for staff.
- Staff said medical staff provided prompt support to children and young people in the SCBU and on the children's ward.
- The hospital used the Embrace critical care transport service, a specialist transport service for critically ill children and newborn infants in Yorkshire and the Humber. The management team and staff of all grades told us that this service worked very well.

Nursing staffing

- Staff in the children's outpatient department and the SCBU told us that there were mostly enough staff on duty to deliver care. Staffing ratios were not based on any formal acuity or dependency tool. We were told they were based on professional judgement.
- The children's ward manager reported that the assessment unit and paediatric ward were fully staffed to the agreed establishment. The staffing establishment fell below the recommended minimum staffing level for children's wards set out by the Royal College of Nursing guidance. This guidance is not mandatory for trusts to follow.
- The children's assessment unit had seven beds/cots. We saw there was one registered nurse on duty each day. Guidance issued by the Royal College of Nursing in 2013 recommends a minimum of two registered children's nurses available throughout opening hours. This unit was part of the overall children's ward and managers told us that, if required, a nurse from the other part of the children's ward would assist the assessment unit nurse. However, our observations suggested this would be difficult as the staffing levels for the rest of the ward were lower than guidance suggested.
- We were told that the normal ratio of staff on the children's ward was one registered nurse to eight patients. At weekends, we saw from the off-duty records, and confirmed with staff, that there were three registered nurses for up to 24 patients. Senior managers told us the ratios were one registered nurse to six patients and the teams could use flexible staffing if the ward required this. However, from our conversations with the ward staff, we were not assured that staff had the ability to implement flexible staffing to increase the numbers of registered nurses when they needed to.
- Guidance issued by the Royal College of Nursing in 2013 recommends that, for children less than two years of age, there should be one registered nurse for three patients. For children older than two, there should be one registered nurse for every four patients. For children receiving level 1 care there should be 0.5 registered nurse for every patient and for children receiving level 2 care, there should be one registered nurse to one patient. Levels 1 and 2 care mean the children need additional monitoring or treatment. This guidance is not mandatory. The trust did not use this guidance to calculate their staffing levels and they did not alter their ratios depending on the age of the children on the unit.
- During our visit, we observed a night shift on the children's ward. There were 14 patients on the ward and one patient in the HDU requiring level 1 care. There were three registered nurses on duty. This meant the registered nurse to patient ratio was one nurse for every 5.6 patients. This meant the ratios of registered nurses were not in line with recommended guidance.
- During the night shift, the remaining beds were open and staff confirmed they could accept up to 24 patients. There was a risk that the registered nurse to patient ratio could become less compliant with the guidance.
- We raised our concerns about staffing levels at the time of our inspection. The trust took immediate action to review the staffing levels on the children's assessment unit and children's ward and implemented an acuity and nursing dependency tool. They also incorporated the assessment unit on to the ward during the weekend and made adjustments during the week to provide safer staffing levels.
- At the unannounced inspection, staff told us they were now using the age of the child to calculate the ratio of nurses to patients, and they were working towards the Royal College of Nursing staffing guidelines for children. We reviewed the staffing levels during the unannounced

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inspection and the service was working to a ratio of 1:4 for patients over two years of age and 1:3 for patients aged under two years. Staff told us the acuity and nursing dependency tool supported decision-making and clearly identified levels of staffing needed on the unit. However, we were unable to assess if the staffing levels could be sustained.

- The trust planned to use a nationally recognised dependency tool to further review staffing levels.
- The neonatal unit critical care service is not fully compliant with the national service specification however NHS England had agreed with the Trust that services may continue to be provided on the current basis whilst a review is undertaken by NHS England, in line with other providers. Staffing levels for the day shift were four registered nurses, one nursery nurse and one healthcare assistant. This allowed one-to-one care for the intensive care babies, one registered nurse to two babies for the high dependency beds and one registered nurse to five babies who required special care. The BAPM guidance states that nurses should not be responsible for more than four babies who require special care. This guidance is not mandatory, but is accepted best practice.
- There was no access to a senior registered children's nurse out of hours to provide support and advice to staff.
- Following the inspection the trust told us that they had taken immediate action to improve staffing levels.

Medical staffing

- The medical staffing was 26 whole time equivalent (WTE) posts with 27% consultant, 4% middle-career (with at least three years at senior house officer or a higher grade within their chosen speciality), 64% specialist registrar 1–6 and 5% junior foundation year 1 to 2.
- Foundation and specialist trainee doctors felt they had good access to training. They felt well-supported by paediatric consultant staff and said consultants were “friendly and visible”.
- Nursing staff said they could access medical staff and felt well-supported.
- There were three patient handovers each day, with at least one being a consultant-led handover.

- The new clinical director had initiated regular weekly meetings with the consultant team and there was a monthly managers meeting which all medical staff could attend.
- There was daily teaching for junior staff and every Friday there was an all-consultant round that used a problem-based learning approach to training.

Major incident awareness and training

- Staff were aware of their responsibilities in the event of a major incident.
- Detailed major incident plans were available and accessible for staff.

Are services for children and young people effective?

Requires improvement



Children and young people's needs were assessed appropriately with care and treatment delivered in line with current legislation.

Staff had not received training to enable them to provide support and care to children who had mental health needs. This was raised at the time of the inspection. At the unannounced inspection, training had been arranged for CAMHS awareness training for all staff to attend.

Staff were not always supported to participate in training and development which would enable them to deliver good quality care. Staff had not received training on the Mental Capacity Act 2005.

Staff did not participate in clinical supervision and did not have regular meetings with their managers.

Outcomes for children and young people, compared with national averages, were within expected range.

Evidence-based care and treatment

- With the exception of children with mental health needs, children and young people received care and treatment based on best practice guidance.
- Children and young people were supported by health play therapists and it was clear that this role contributed to positive outcomes. Play therapists were available seven days a week.

Services for children and young people

- The children's ward had established links with a local specialist children's trust. Staff could attend training. There were strong working links in place to support staff, children and young people.

Pain relief

- The service used an evidence-based pain-scoring tool to assess the impact of pain. Staff told us the pain-scoring tool was incorporated into the PEWS assessment tool that was completed by members of staff.
- We looked at the medical and nursing records of 11 children. One record showed that a child appeared to be in pain through discussion with the family and observation of the child, but the pain section on the PEWS chart had not been completed.

Nutrition and hydration

- Staff completed nutritional risk assessments for children and young people.
- Children and young people were offered a choice of meals that were age-appropriate and supported individual needs such as gluten-free diets.

Patient outcomes

- The multiple admission rate for children and young people aged up to 17 years with asthma was higher than expected.
- The number of unplanned hospitalisations for asthma, diabetes and epilepsy in under 19s was lower than expected. The readmission rate for the year to October 2014 was 135 against a target of 630, which meant that the rate was better than expected.
- The number of emergency readmissions for children with lower respiratory tract infections was lower than expected. The readmission rate year to October 2014 was 167 against a target rate of 214. This was better than expected.
- The National Paediatric Diabetes Audit data published December 2013 showed the results for the trust were as expected.
- The neonatal mortality rate (for the labour ward and neonatal unit) was one death for the year to October 2014. This was lower than expected for the trust.
- There was a higher risk of readmission than the English average for non-elective general surgery.

- Clinical areas in children's services submitted on-going data to the patient Safety Thermometer performance monitoring dashboard. Data showed that all children's clinical areas scored as 100% harm-free care between April 2014 and December 2014.
- In-hospital mortality for paediatric and congenital disorders from 1 May 2013 to 30 April 2014 was within expected limits for the trust.
- There was limited evidence to identify how the department showed that clinical interventions resulted in positive patient outcomes. An annual audit plan was in place and was reviewed and monitored by the trust's clinical effectiveness committee. The annual audit plan deadlines were delayed. This meant there was limited evidence to show that clinical interventions resulted in positive patient outcomes. For example, the audit of National Institute for Health and Care Excellence (NICE) guideline on antibiotics for early onset neonatal sepsis (guideline CG149) was due to be finished in 31 January 2015; it had not been completed at the time of the inspection. It was unclear why the audit plan deadlines were delayed.

Competent staff

- All staff had received an annual appraisal between April 2013 and April 2014. All appraisals were undertaken in the new trust format which reflected the trust's visions and values.
- All staff had completed training in tracheostomy care.
- Staff had not received training on the Mental Capacity Act 2005. Staff did not know how and when a person's mental capacity to consent to care and treatment should be assessed and recorded.
- Staff had not received training to enable them to provide support and care to children who had mental health needs. We raised this during our inspection and, at the unannounced inspection, we found that CAMHS awareness training had been arranged for all staff.
- A standard operating procedure was in place for admissions to the HDU and the majority of band 6 staff were HDU trained.
- Students had an induction on the ward and were allocated two mentors during their placement on the ward.
- Staff did not routinely receive clinical supervision.
- Following our inspection the trust was recruiting a senior nurse with a children's qualification to provide support for staff.

Services for children and young people

Multidisciplinary working

- Staff told us how they worked with other healthcare professionals, such as dieticians, physiotherapists and health visitors to ensure that children and their families received the care and treatment they required.
- Nursing staff gave positive examples of multidisciplinary team working. We were told that paediatricians and nursing teams worked closely with each other to ensure positive outcomes for children and their families.
- Children and young people were supported by health play therapists.
- We found that the input from partner organisations regarding the care of children with mental health needs was limited. We raised this at the time of the inspection and steps were taken to improve interdisciplinary working.

Seven-day services

- There were seven-day consultant ward rounds.
- All children and young people were reviewed by a consultant every day as a minimum. However, depending on clinical need, this was increased.
- There was consistent medical staff presence during our inspection. Parents and staff supported this.
- An early review following discharge was available through the children's admission unit for patients who needed this.
- There was seven-day access to x-ray and radiology.

Access to information

- A range of information leaflets was available about various treatments and care. However, some of the information did not reflect current NICE guidance – for example, the management of fever in children was written in 2004 and had not been updated to reflect NICE guidance Feverish illness in children from May 2007.
- The service did not have information that was age-appropriate so children of different ages did not receive information leaflets written for their age and understanding.
- Language translation services were available and staff confirmed that these were used.

Consent

- The paediatric ward had a pre-assessment nurse who held clinics for elective surgery which meant that consent was mostly recorded before the day of surgery. This gave the parent and child sufficient time to weigh up the benefits and risks of surgery.
- Staff we talked with showed that they understood the Gillick competency standard used to decide whether a child is mature enough to make decisions and give consent.

Are services for children and young people caring?

Good



Staff treated children, young people and their families with compassion, kindness, dignity and respect. Staff built positive relationships with children, young people and their families and took the time to talk to patients; their families valued the relationships with staff.

Compassionate care

- Children, young people and parents told us they felt they received compassionate care with good emotional support.
- Staff ensured patients' privacy and dignity was respected when they received physical or intimate care.
- During our inspection, we observed members of medical and nursing staff provided compassionate and sensitive care that met the needs of the child, young person and parents. However, we observed the care of one child who was not treated with compassion and dignity. We raised this at the time of the inspection and action was taken to ensure this child was treated with dignity, respect and compassion.
- We observed that members of staff had a positive and friendly approach towards the child and parents. Staff explained what they were doing, for example, completing their clinical observations.
- The trust had introduced the NHS Friends and Test on the children's ward and SCBU. The ward achieved a response rate of 33% and scored 86% for patients agreeing they would recommend the children's service to friends and family. The trust received one negative comment which the ward manager had responded to.

Services for children and young people

- The SCBU achieved a response rate of 100% and all respondents said they would recommend the service to family and friends.

Understanding and involvement of patients and those close to them

- Members of staff who talked with children and young people used age-related language to suit the level of understanding. However, staff sometimes focused on the task rather than the children and young people as individuals. This meant there was a risk children were not treated as individuals.

Emotional support

- The trust had links between children and young people's services and CAMHS.
- The service did not currently have formal arrangements to respond to the transitional needs of adolescents moving to the adult services for all pathways, but did have them for diabetes, epilepsy and asthma.
- Play therapy services included distraction therapy, emotional support and pain management.

Are services for children and young people responsive?

Requires improvement



We rated the responsiveness of the service as requiring improvement.

Services were not always delivered in a way that met the needs of all young people, such as those who had mental health concerns. The approach to meeting the needs of different groups could be reactive.

Children who had surgery were nursed in the same recovery as adults.

Action and learning from complaints was not widely disseminated.

Service planning and delivery to meet the needs of local people

- The hospital used the Embrace specialist transport service for critically ill children and newborn infants in Yorkshire and the Humber.

- The trust was part of the network of paediatric provision within South Yorkshire.
- There were some gaps in how well the directorate understood the needs of different groups of patients. For example, staff did not always manage and respond appropriately to CAMHS patients with eating disorders. We also found that they were not able to recognise the needs of patients who were trans-gender.
- Children and young people were nursed together in single-sex bays.
- The children's outpatient department provided a supportive, age-appropriate environment for children and young people and provided a range of activities for children and young people to access while they waited for their appointment. There was a designated teenage area available.

Access and flow

- The length of stay was in line with the national average. Staff told us the average length of stay for children was 1.5 days.
- There were 42 elective admissions (based on a discharge) in October 2014 compared to the target rate of 19.
- The average length of stay for elective admissions was two days in October 2014.
- There was no admission criteria for accepting young people at risk of self-harm who required one-to-one supervision by registered staff.
- Rates for patient non-attendance for an initial outpatient appointment were monitored by the trust and within the children's outpatient department. Information reported by the trust showed an increase from 12% in April 2014 to 13% in July 2014.
- Non-attendance follow-up rates were also monitored by the trust and within the children's outpatient department. Information reported by the trust showed a decrease from 15.3% in April 2014 to 11% in July 2014.
- The directorate had introduced a rapid access clinic Monday to Friday to meet the needs of children and young people in the area.
- Children who had surgery were nursed in the same recovery area as adults. Curtains were used to separate the area. Children were transferred to the recovery area through the adult recovery area. Royal College of Anaesthetists guidelines for providing anaesthetic to children stated, "Children should be separated from, and not managed directly alongside adults, whether in

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the operating department (including reception and recovery areas), inpatient wards, day ward or critical care unit” (Guidelines on the Provision of Anaesthetic Services 2015).

Meeting people’s individual needs

- There were some health information leaflets available; however, these were largely out of date and in a corporate style which was not child-friendly. For example, the fever leaflet was dated 2004 prior to the NICE guidance on management of fever. The ward manager told us they did not have any child-friendly leaflets and had not involved children or young people in leaflet design and development.
- There were two playrooms – one for children under 12 and one for those aged over 12 years. They included a large variety of play equipment to accommodate a variety of ages and needs on the inpatient ward. There was also a quiet room for those over 12. However, this was a very small room and was cluttered with computers being stored in the room.
- Toys, games and books could be provided at bedsides.
- Educational needs and school support were provided externally. Children and young people had access to home school services if they were in hospital for longer than three weeks. There was a schoolroom on the ward, but this was no longer in use.
- The hospital does not have formal adolescent transitional arrangements for all pathways but does have them for diabetes, epilepsy and asthma. There was no overarching transition policy or pathway for transition.
- The service was able to access language interpretation services.
- Parents were encouraged to stay on the ward with their children and we were told the staffing levels would not be sufficient to care for the children if the parents did not stay. It is important that the ward is able to offer suitable facilities for parents. None of the parents we spoke with expressed concern about the facilities available for them.
- There were parents’ beds in the cubicles and truckle beds for parents in the ward bays to allow them to stay with their children.
- Parents had access to an extremely small kitchen area, but there was a lounge for them to use.
- The ward was decorated appropriately for a children’s ward and was light and well-maintained.

- Play areas were well-equipped and age appropriate. A sensory room was available for children to use.
- There was a rooftop play area which had age-appropriate equipment. However, it was not in use following a significant incident in September 2014. This meant that children were unable to access an outside space.

Learning from complaints and concerns

- Staff and managers told us that few complaints were received and any verbal complaints were usually resolved straight away.
- No clear themes had been identified in the complaints received.
- Learning from complaints was not widely shared within the teams. Nursing staff we spoke with were not aware of any lessons learned.

Are services for children and young people well-led?

Inadequate



We rated the leadership within the service as inadequate.

The vision and values for the service were not established. Governance arrangements were unclear and provided limited assurance in identifying managing risks and concerns. There was a limited approach to the management of risk and it was unclear who was responsible for reviewing and managing identified risks.

Vision and strategy for this service

- During our interview with the senior management team, we were unable to establish that the management team held a clear vision for the children’s service.

Governance, risk management and quality measurement

- Ward managers told us that they attended monthly clinical governance meetings.
- The governance arrangements and their purpose were unclear. The service had introduced a governance lead role who attended the children and young people’s governance meeting and took the lead for monitoring

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and overseeing risk. Staff were aware of the local risk structure, however, the processes, and who to contact for escalating risks and concerns, were not sufficiently embedded throughout the service.

- Formal assessment and mitigation of risks did not appear to have been seen as a priority. The risk register we were provided with did not include some of the areas our inspection raised as significant concern.
- There were four high risks documented on the children and young people's risk register. However, we saw that limited action had been taken to address these concerns. For example, in February 2014, staff raised a concern about the national shortage of CAMHS tier-four service provision and that children were being admitted to the children's ward as a place of safety. The risk score was 15 which meant the risk was high. The register contains a section for actions to be taken to reduce the risk. We saw in relation to the CAMHS risk the register stated, "There are no mitigating actions. There are no services for many of these children. Chief nurse is seeking a meeting with the multi-agency partners. A long review date has been set because there will be no 'quick wins'." Following a review on 31 December 2014, the risk remained at 15. One consideration could have been to ensure that ward staff were trained and felt competent to care for these children. This meant even though a risk had been identified, no action had been taken to try and reduce the risk. This put children at risk of harm.
- During the inspection, we were not assured that governance procedures would maximise the opportunity to identify, report and learn from incidents to improve services.

Leadership of service

- The senior management team informed us that the medical clinical lead for children post was vacant.
- They did not have access to a senior paediatric nurse at all times. We raised this as a concern at the time of our inspection. Following the inspection, the trust were

committed to securing a senior paediatric nurse to undertake a review of the nursing service. This review would include consideration of the role of a senior nurse and access to support 24 hours a day.

- Leadership throughout the service had lacked stability and direction because of staff sickness and vacancies. The senior team had all been in post for less than a year.
- However, most staff supported their new managers and felt the recent changes would improve patient care and their work experience.

Culture within the service

- We found a culture of openness and flexibility among all medical, nursing and allied healthcare professional staff on the wards and within the children's service. Staff spoke positively about the care they provided for children, young people and their families.
- We saw how staff placed the child and the family at the centre of care delivery, and how this was seen as a priority and everyone's responsibility.
- Staff worked well together and there were positive working relationships between the multidisciplinary teams and other services involved in the delivery of care for children, such as the A&E department.




Public and staff engagement

- Staff told us they generally felt able to raise concerns or ideas for improving the service with managers and felt they would be listened to. However, staff told us they did not have regular team meetings.
- We found that patients' experiences of the service were regularly sought. The NHS Friends and Family Test was used to gain the views of children, young people and families about their experiences.

Innovation, improvement and sustainability

- A consultant-led rapid access clinic was in place, allowing GPs to get prompt specialist advice and promptly implement care pathways for children and young people.

End of life care

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

Information about the service

Patients with end of life care needs were nursed on the general wards throughout Rotherham Hospital. They were supported by a consultant-led specialist palliative care team (SPCT). This team provided specialist advice and support as requested and coordinated and planned care for patients at end of life on the wards. The palliative care team were integral to the multidisciplinary team in the hospital and the community and were responsible for inpatients in the hospice. The Trust had a contract with the hospice.

The SPCT was available week days from 9am to 5pm, excluding bank holidays. Out-of-hours consultant support and advice was provided by a telephone hotline based at the local hospice.

We visited wards where end of life care was provided, the bereavement centre, the multi-faith centre and the mortuary. During our inspection, we spoke with patients, relatives and members of staff, including nurses, doctors, healthcare assistants, the chaplain, mortuary technicians and staff in the bereavement centre.

We observed interactions between patients, their representatives and staff. We considered the environment, and looked at 12 care records. Before our inspection, we reviewed performance information from and about the hospital.

Summary of findings

End of life care services included measures to minimise risks to patients and monitor the prevention and control of infection, management of medicines and safeguarding people from abuse. Dedicated teams supported staff and ensured that policies and procedures were implemented. Staff were familiar with the process for reporting incidents, near misses and accidents and were encouraged to do so.

We checked 35 do not attempt cardio-pulmonary resuscitation (DNA CPR) forms on wards throughout the hospital and found there were inconsistencies in how these were completed. This mainly related to how the capacity of patients unable to make decisions about DNA CPR was assessed.

The trust had replaced the Liverpool Care Pathway for end of life care with individualised care plans from nursing documentation for end of life care patients.

Patients approaching the end of life were identified appropriately and care was delivered according to their personal care plan, including effective relief of pain and other symptoms which were regularly reviewed. Patients in the last days of life were identified in a timely way and appropriate action was taken. Patients' pain was well-managed and appropriate prescribing took place to manage symptoms such as nausea and vomiting or agitation.

We saw that patients were treated with compassion, dignity and respect. Patients and their representatives

End of life care

spoke positively about their care and told us that they felt included in their care planning. We observed a good, caring approach by the mortuary and bereavement staff.

The trust did not have a rapid response policy for end of life care patients who preferred to die at home. However, we were told that this could be facilitated within two to three hours with the support of the hospice rapid response team, the trusts specialist palliative care team and the continuing healthcare team. The trust did not collect this data so we were unable to corroborate this. Data from the trust stated that 93% of patients on the end of life care pathway had died in their preferred place in the last year.

There was a multi-faith prayer room, including screens for separate gender areas for people practicing the Muslim faith. The responsiveness of mortuary and bereavement staff to the needs of parents who had lost children or babies was an example of good practice.

There was a vision and strategy for the end of life care service. There was an increase in investment and staff to support a seven-day, face-to-face service by the SPCT. The trust's specialist palliative care clinical governance group provided a forum for clinical governance development, implementation and monitoring across the hospital's specialist palliative care services. An identified executive director was the lead for end of life care.

Risk management and quality assurance processes were in place at a local level. The end of life service held governance and patient safety meetings. Records showed that risks were escalated, included on risk registers and monitored each month.

Team-working on the wards between staff of different disciplines and grades was good.

Staff in the SPCT spoke positively about the service they provided for patients and were passionate about their work. The mortuary and bereavement staff culture was very positive and enthusiastic about the provision of care at the end of a person's life. This was demonstrated through their approach to patient care.

There were no specific consultation groups in the trust to allow patients and the public to contribute to the

development of end of life care services. The SPCT acknowledged that there was work to be done to improve end of life care services throughout the trust. The team had compiled a five-year plan to address this.

End of life care

Are end of life care services safe?

Good



End of life services were safe.

There were measures in place to minimise risks to patients and monitor the prevention and control of infection, management of medicines and safeguarding people from abuse. Dedicated teams supported staff and ensured that policies and procedures were implemented.

Staff were familiar with the process for reporting incidents, near misses and accidents and were encouraged to do so.

Incidents

- There were no serious incidents or Never Events reported for the end of life care service between April 2013 and April 2014.
- The staff we spoke to were aware of how to report incidents and felt confident in doing so.
- We saw evidence of learning from incidents. Staff confirmed they had received feedback from the SPCT concerning incidents raised by patients. Feedback was shared during team meetings and handovers.
- The SPCT told us that there were very few reported incidents relating to end of life care. We saw documentation that showed there was one incident where a junior doctor had recommended administering medication to an end of life care patient. However, this recommendation was reviewed and changed by the SPCT. The incident was reported using the hospital's electronic incident reporting system and reviewed by the clinical director for medicine.

Cleanliness, infection control and hygiene

- Appropriate guidance was followed in the mortuary for maintaining a clean environment and reducing the risk of infection.
- Staff were observed to be wearing the appropriate personal protective equipment.

Medicines

- We saw that there were systems to protect patients against the risks associated with the unsafe use and management of medicines.

- There were appropriate systems for the safe storage and checking of controlled drugs and syringe drivers. On the wards we inspected, we saw that all medicines were stored safely and that record-keeping was in accordance with the trust's policy. Controlled drugs were being managed in accordance with the Controlled Drugs Regulations 2013.
- We observed two patients whose medication was delivered by syringe driver. This was being delivered and monitored appropriately.
- The trust told us that a training programme covering the use of syringe drivers was in place. We saw documentation showing that 94.2% of staff had been trained by the medical devices team on the use of the McKinley syringe driver.
- We saw that the medical devices team tracked the use of syringe drivers throughout the hospital and for patients using currently discharged devices.
- We observed staff and saw documentation showing that staff complied with guidelines for prescribing medicines for patients receiving end of life care and reviewed records to ensure that national guidelines were followed. This meant that patients were protected against the risks associated with the unsafe use and management of medicines.
- The SPCT had developed guidance on anticipatory prescribing for inpatients and those patients being discharged from the hospital. The guidance included pain relief and medicines to control nausea and vomiting.
- The SPCT had worked with the local hospice to ensure there was consistent practice in prescribing medicines at the end of life.
- There were two nurses in the SPCT who were non-medical prescribers (nurses able to prescribe any medicine for a health condition, within their field of expertise). They had received the required training to undertake this role.

Records

- The service had a centralised, computerised patient coordination system which contained information about the end of life patients in the hospital.
- The patient coordination system, as well as tracking end of life care patients throughout the hospital, would alert the SPCT if a patient requiring end of life care was being treated in the emergency department. This was good practice.

End of life care

- We saw evidence that the SPCT were reviewing records of patients who were at the end of life. The SPCT reviewed these patient records daily to gain up-to-date information on patients' conditions.
- During our inspection, we saw that the trust was using individualised care plans in their nursing documentation for end of life care patients.
- The trust was in the process of developing an individualised care plan based on the five priorities of care from One Chance to Get it Right: Improving people's experience of care in the last few days and hours of life, published by the Leadership Alliance for the Care of Dying People, setting out the approach to caring for dying people that the organisation believes health and care organisations and staff caring for dying people in England should adopt.
- We reviewed one fluid balance chart for a patient receiving palliative care who was receiving intravenous fluids (via a drip). The chart was accurately completed.
- We also saw appropriate nutritional assessments documented for patients receiving end of life care.
- On all the wards we inspected, patients' clinical notes were stored securely on notes trolleys. This meant that patient confidentiality was maintained, while giving easy access to the nursing and medical staff.

Safeguarding

- There were effective safeguarding policies and procedures that were understood and implemented by staff.
- Staff providing end of life care were aware of the trust's whistleblowing procedures and what action to take. Trust data showed that most staff providing end of life care had received mandatory training in safeguarding children and vulnerable adults.
- Staff we spoke with demonstrated a good understanding of the safeguarding policies and procedures and what to do should a safeguarding situation arise.

Mandatory training

- End of life care training was not classed as mandatory by the trust, however, staff told us that training had been provided by the consultant in palliative medicine in the last year for medical and nursing staff. We were not clear how many staff had been trained.
- There was training relating to the new care plan for last days of life which was to be piloted on one ward in

March 2015. Should the pilot be successful and the training approved, further training across specialisms, including allied healthcare professionals, was planned for 2015.

Assessing and responding to patient risk

- Risk assessments used for patients at the end of life were the same assessments as patients receiving care for any other condition. The trust used the Waterlow risk assessment for pressure sores and malnutrition universal screening tool (MUST) for nutritional assessments. There was no assessment tool to recognise the dying patient, however, the clinical notes recorded when a patient had been identified as being in the last days or hours of life.
- The nursing staff we spoke to on the wards said the SPCT would review a patient within 24 hours of a referral. Referrals could be made outside of normal working hours to the on-call palliative care nurse.

Nursing staffing

- The specialist palliative care nursing team comprised of two specialist nurses who worked week days, with another specialist starting in March 2015. A further post was due to be advertised.
- The SPCT told us that, with additional staff, they would have the capacity to take on more teaching and service improvement.
- We observed a morning handover between staff on one ward and we saw that printed handover sheets were used which listed people's conditions and treatment. Staff gave detailed handovers, including the patient's comorbidities (having two or more diseases at the same time).

Medical staffing

- The SPCT included two whole time equivalent (WTE) consultants in palliative care. The team worked week days during normal office hours, with an out-of-hours advice line for weekends and night cover, which included a palliative care consultant who would undertake out-of-hours visits in an emergency. We were told that the team had not currently filled its staffing complement, but expected to do so within six months, and would then anticipate providing a 24-hour, seven-days-a-week service.
- Medical staff told us there were effective medical handovers in place. These varied according to the

End of life care

specialty. For example, some specialties had a consultant-led handover each morning, with a more informal on-call handover in the evening between the doctors.

Major incident awareness and training

- The mortuary manager told us (and we saw documentation that showed) that there was a contingency plan to follow in the event that the mortuary's body storage facility became full.

Are end of life care services effective?

Requires improvement 

The effectiveness of the end of life care service required improvement.

We checked 35 DNA CPR forms on wards throughout the hospital and found there were inconsistencies in how these were completed. This mainly related to how the capacity of patients unable to make decisions about DNA CPR was assessed.

Services were evidence-based and focused on the needs of patients. We saw examples of good collaborative working in addition to good patient-focused practice.

Evidence showed that patients approaching the end of life were identified appropriately and care was delivered according to their personal care plan, including effective relief of pain and other symptoms which were regularly reviewed. Patients in the last days of life were identified in a timely way and appropriate action was taken.

The trust had replaced the Liverpool Care Pathway for end of life care with individualised care plans from nursing documentation for end of life care patients.

Patients' pain was well-managed and appropriate prescribing took place to manage symptoms such as nausea and vomiting or agitation.

Evidence-based care and treatment

- The trust's end of life care policy was based on the National Institute for Health and Care Excellence (NICE) quality standards and the priorities detailed in One Chance to Get it Right: Improving people's experience of care in the last few days and hours of life, by the Leadership Alliance for the Care Dying People.

- Since the withdrawal of the Liverpool Care Pathway in 2014, the trust was using its nursing documentation to develop individualised care plans for end of life care patients. We saw that the first draft had been produced and we were told it would be trialed in the hospital in March 2015. The care plans were based on the five priorities of care from One Chance to Get it Right. In the interim, staff were writing their own care plans.
- We looked at the care records where staff had developed a care plan. The care plans gave clear guidance for staff to meet the patients' needs in respect of repositioning, food and fluid intake and pain relief.
- All the records we reviewed during the inspection demonstrated that care followed NICE Quality Standard QS13. This quality standard defines clinical best practice for end of life care for adults.
- The trust told us they did not participate in Transforming end of life care in acute hospitals (the Transform programme). The Transform programme focuses on improvements to the quality of care provided by acute hospitals, as well as their role in providing end of life care.
- One of the key elements of the Transform programme is the 'amber care bundle', an alert system to identify patients not responding to treatment and a systematic approach to manage the care of patients who are facing an uncertain recovery and who are at risk of dying in the next one to two months.

Pain relief

- Providing effective pain relief for patients receiving end of life care was seen as an essential aspect of the SPCT's role.
- During our inspection we saw that patient's pain was well-managed. The pain was assessed and appropriate pain-relief medication was prescribed.
- None of the patients or relatives we spoke with told us they were concerned about pain relief.
- Controlled drugs were given in a timely way and staff told us they prioritised this.
- Two of the nurses in the SPCT could prescribe pain-relief medication for patients.
- Appropriate anticipatory prescribing of medication took place to control the symptoms of agitation, restlessness, nausea and vomiting.

Nutrition and hydration

End of life care

- Nutrition and hydration assessments were completed for all patients as appropriate. These assessments were detailed and used a MUST nutritional assessment, a nationally recognised nutritional screening tool.
- We observed that patients had access to food, drinks, and were able to reach them. Where patients had difficulties with eating and drinking, we observed them being assisted by hospital staff.
- There were various menus which incorporated the dietary requirements of different cultures and religions.
- The trust took part in the National Care of the Dying Audit 2014 and scored 65% for review of patients' nutritional requirements, which was better than the England average of 41%.
- The trust scored 67% for review of patients' hydration. This was better than the England average of 50%.

Patient outcomes

- In the National Care of the Dying Audit of Hospitals 2014, the trust failed to achieve six out of the seven organisational key performance indicators. The SPCT told us that they were working with the end of life steering group to review the audit and create an action plan to address the issues identified.

Competent staff

- New staff received mandatory training as part of their induction programme.
- We spoke with the porters about the training they had received. They told us that training was given on moving and handling and equality and diversity.
- End of life care training was not part of the trust's mandatory training programme. The SPCT told us that they were responsible for providing end of life care training for ward staff. We were not clear how many staff had been trained.
- The SPCT told us they had been given a slot to teach on the junior doctor's induction programme commencing in July 2015.
- All members of the SPCT received appraisals as well as clinical supervision and these were up to date.
- There were no palliative care link nurses on the wards. We were told that this was due to staff changes and was planned for the future when the SPCT was fully staffed. This would enable the SPCT to disseminate information through the links to the ward staff.
- The SPCT had held a communication skills day in October 2014 for junior doctors.

- The trust had held an event for staff called "One Chance to Get it Right." This was attended by members of the multi disciplinary teams.

Multidisciplinary working

- All nurses from the SPCT attended the monthly cancer multidisciplinary team meetings.
- We spoke to staff and reviewed records, which confirmed that effective multidisciplinary team working practices were in place.
- Staff told us there was effective communication and collaboration between teams who met regularly to identify patients requiring end of life care.
- The chaplain was also part of the multidisciplinary team for end of life care patients.
- The SPCT had an effective relationship with the hospice and ensured that patients nearing the end of life were referred to the team in a timely fashion. Staff told us that patients referred to the team were seen within 24 hours of referral and reviewed on a daily basis.
- Nursing staff on the ward were very complimentary of the work of the SPCT and said they worked very well together.
- The service used an electronic palliative care coordination system to support care so that people's choices about where they died and the nature of their care was respected and achieved wherever possible. This enabled key medical information and conversations about end of life care wishes to be communicated across medical areas, including with external providers and services.
- The results of the National Care of the Dying Audit 2014 showed that the trust was significantly below the national average for multidisciplinary recognition of when a patient was dying. The national average for England was 61%; the trust scored 40%. The SPCT told us that they were working with the end of life steering group to create an action plan to address the issues identified.
- The chaplain was part of the multidisciplinary team who worked in end of life care and supported patients, families and staff as required.

Seven-day services

- The National Care of the Dying Audit of Hospitals 2014 found that 73% of trusts provided face-to-face services on weekdays, with 21% providing a face-to-face palliative care service seven days per week.

End of life care

- The SPCT worked week days during normal office hours. There was an out-of-hours advice line from the local hospice for weekends and night cover which included a palliative care consultant attached to the local hospice who would undertake out-of-hours visits in an emergency.
- The chaplaincy service provided pastoral and spiritual support and could be contacted out of hours.
- The mortuary provided a 24-hour, seven-days-a-week service to the trust and the community.

Access to information

- The SPCT had access to up-to-date information on their patients using the hospital's electronic patient record system.
- GPs were sent information on all end of life patients discharged into the community.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All DNA CPR decisions were recorded on a standard form, kept at the front of the patient's clinical notes to allow easy access in an emergency. All were completed in handwriting that was easy to read.
- The DNA CPR forms were recognised by the community services and were transferable between the acute hospital and the community. This meant that a decision concerning a DNA CPR would be recognised in both sectors without a new form having to be completed. This was good practice.
- We checked 35 DNA CPR forms on wards throughout the hospital and found that there were inconsistencies in how these were completed. The inconsistencies mainly related to the assessment of patients' capacity to make decisions about DNA CPR.
- One DNA CPR form that had been completed for a patient in the medical assessment unit. The patient did not have the mental capacity to understand the decision and there was no record of the mental capacity assessment to show that the decision not to resuscitate was made in the patient's best interest.
- A DNA CPR form had been completed for a patient in A&E. The form stated "patient confused", however, there was no mental capacity assessment form in the patient's clinical notes.
- On Ward A5 we examined five DNA CPR forms and found that, in three cases, the patient's mental capacity had not been considered. On one of these forms, the reason

for completion was recorded as "frailty". Also, in the 'discussed with patient' box, the staff member had written "Has dementia". There was no assessment in the patient's clinical notes to show that their mental capacity had been properly considered.

- We saw three DNA CPR forms on Ward A3. On two of the forms, the 'discussed with patient' box was not ticked and no reason was given. One of the forms stated "patient lacks capacity". We did not see a mental capacity assessment in the clinical notes for either of these two patients. This meant we could not be certain if the patients' mental capacity had been considered.
- On Fitzwilliam Ward we saw one DNA CPR form that had not been discussed with the patient; the reason given was "patient unable to communicate".
- On the high dependency unit we saw a DNA CPR form which stated a decision had not been discussed with the patient as they lacked capacity. However, we could not find a mental capacity assessment in the patient's clinical notes. Staff were unable to tell us why this assessment had not taken place. We spoke to the patient; they were able to speak to us in a way that suggested they were able to make a reasonable decision about their care needs.
- On Ward A2 we looked at four DNA CPR forms, all of which had been discussed with the patients.
- We looked at the trust's policy on cardiopulmonary resuscitation which was issued in December 2011 and was due for review in 2014. It stated that, "for the patient, who is not competent to make a decision about resuscitation, enquire about previous wishes from the relevant others to help the clinical team make the most appropriate decision. Continue to communicate progress to them. Patients should be managed according to the principles of the Mental Capacity Act (2005)."
- The trust had undertaken an audit on DNA CPR forms in January 2015. This found that, out of the 70 forms audited throughout the hospital, just nine (13%) had been completed correctly.
- On two wards we were shown a 'screening tool' for mental capacity assessments which both ward managers told us they completed for all patients on their ward. This was not in accordance with the principles of the Mental Capacity Act 2005 or the trust's policy on when to undertake mental capacity

End of life care

assessments. We spoke with the safeguarding lead for the trust, who confirmed that only if a patient's mental capacity was in question, should the screening tool be completed.

Are end of life care services caring?

Good



End of life care services were caring. We saw that patients were treated with compassion, dignity and respect. Patients and their representatives spoke positively about their care and told us that they felt included in their care planning. The caring approach by the mortuary and bereavement staff that we observed was also good.

Compassionate care

- We observed throughout our inspection that staff spoke with compassion, dignity and respect regarding the patients they cared for in accordance with the National End of Life Care Strategy (Department of Health, 2008).
- We observed positive interactions between staff and patients. On every ward we inspected, patients were treated with compassion and empathy.
- We observed staff speaking with patients and providing care and support in a kind, calm, friendly and patient manner.
- Patients and relatives told us that they were treated respectfully by staff and commented positively about the care that was given.
- We spoke with the relatives of a patient who was receiving end of life care; they described the excellent support received from the nursing and medical staff.
- The chaplain told us about two weddings and a blessing that had been conducted in the 'purple butterfly' room for patients in the last few days of their life.
- We saw that all end of life care patients were placed in side rooms on the wards, unless they requested otherwise. This provided privacy for the patient and their friends and relatives. We also saw that there were facilities available for families to stay with their loved one should they wish to do so.
- The hospital porters told us that they had received training regarding the movement of deceased patients between the wards and the mortuary. The training included how transporting the deceased should be undertaken in accordance with the trust's policy and

procedure. The training also included how the porters should ensure that the deceased were treated with dignity and respect. Documentation demonstrating the porter's attendance at training was also reviewed.

Understanding and involvement of patients and those close to them

- Most relatives said they had been fully involved in end of life care planning for their relative; one relative we spoke to said they had not seen a care plan.
- The results of the National Care of the Dying Audit 2014 showed that the trust was above the national average in relation to health professionals' discussions with the patient and their relatives or friends about their recognition that the patient was dying. The audit also identified the trust as being significantly higher than the national average for communication about the patient's plan of care for the dying phase.
- Patients and family members we spoke with told us that they felt included in their care planning.

Emotional support

- The trust had no formal counselling service for end of life care patients or their loved ones. The SPCT told us that the patient's GP was contacted to make a referral to external services if required.
- There was no counselling available for staff working with end of life care patients. However, the trust was working with Macmillan charity to implement "Schwartz rounds" which would provide a form of supervision and counselling for staff.
- The National Care of the Dying Audit 2014 identified the trust as above the national average for assessing the spiritual needs of the patient and their family.
- The chaplaincy service provided a 24-hour, seven-days-a-week, on-call service for patients and their relatives in the hospital. The main prayer room had a place for people to request the prayer of their choice.
- The chaplaincy service told us that they conducted last rites and blessed the deceased in the mortuary as required.
- The chaplain worked closely with the SPCT and would attend with the team, as necessary, to see patients when there was a need to break bad news.

End of life care

- We were told by the mortuary manager that relatives were supported by the mortuary staff. Staff explained to relatives what to expect when they viewed their deceased relative.
- The mortuary manager told us they accommodated all faiths and worked closely with Muslim and Jewish undertakers to ensure deceased patients were cared for in accordance with their cultural and religious requirements.
- The bereavement and mortuary staff supported families in need of assistance with the planning of funeral arrangements through local services; they also supported with cremation and burial arrangements, in addition to other tasks to support the bereaved.
- The bereavement staff explained their process for families who lose children or babies.

Are end of life care services responsive?

Good



The responsiveness of the service was good.

Patients who were referred to the SPCT were seen according to their needs. The team was committed to ensuring that patients receiving end of life care services had a positive experience.

The SPCT were available 9am to 5pm, Monday to Friday (but not bank holidays). Where patients had been identified as being in the last eight weeks of their life, the SPCT engaged the support of the hospice. The hospice's rapid response team could facilitate a patient's wish to return home within two to three hours. The trust did not collect this data so we were unable to corroborate this. Data from the trust stated that 93% of patients died in their preferred place in the last year.

The multi-faith prayer room accommodated a range of faiths and used screens to separate genders for practicing Muslims.

The responsiveness of mortuary and bereavement staff to the needs of parents who had lost children or babies was an example of good practice.

Service planning and delivery to meet the needs of local people

- The SPCT used demographic data to develop and plan services.
- Since the withdrawal of the Liverpool Care Pathway, the trust was developing an individualised care plan document for end of life care. This was not in place at the time of the inspection.
- The trust did not have a rapid response policy for end of life care patients who preferred to die at home. We were told however that a patient's wish to return home could be facilitated within two to three hours, with the support of the hospice rapid response team. The trust did not collect this data so we were unable to corroborate this. Data from the trust stated 93% of patients on the end of life care pathway died in their preferred place of death in the last year.
- The SPCT worked closely with patients who were at the end of their life and their families to ensure that care was carried out in the patient's preferred place. The SPCT's criteria said that referrals could be made to them at any time from diagnosis to death. This meant that there could be early involvement by the SPCT so they could facilitate the most appropriate care available while working in a multidisciplinary way with their colleagues.
- The SPCT saw patients within 24 hours of a referral.

Meeting people's individual needs

- Fitzwilliam Ward had a self-contained unit with a bedroom, en-suite bathroom, kitchen and sofa bed. This was called the 'purple butterfly' room and it was a place where patients could spend the last few days of life and where family could stay with them. The room was decorated in white and lilac with stars on the ceiling that lit up at night. It was away from the main ward so there was little or no noise disruption. Families and loved ones were able to stay there continuously.
- Fitzwilliam Ward also had a 'renaissance room' – a room with various ornaments and areas set in the 1950s and was used for patients living with dementia.
- The SPCT facilitated the care pathway and visited end of life patients as appropriate to their needs. A 'RAG rating' system (Red, Amber, Green) was used to prioritise patients.
- The mortuary waiting room was clean, fresh, modern and provided facilities for relatives, such as comfortable seating and information booklets about bereavement and the trust's bereavement service. The mortuary had a viewing suite where families could visit their relatives.

End of life care

We visited this area and saw that the viewing suite was divided and had a separate waiting and viewing room. The suite was neutral with no religious symbols which allowed it to accommodate people of all faiths.

- Facilities were available for the bereaved to wash the deceased, if required.
- The trust's bereavement service provided support for relatives following the death of a patient.
- Death certificates were available between 9am and 5pm, Monday to Friday.
- On all wards we saw there were bereavement packs with the sign of the purple butterfly on the front page. These packs were given to relatives of the deceased and included all of the necessary information on what process would be undertaken after a bereavement.
- The SPCT told us that they did not undertake a post-bereavement questionnaire for families.
- Viewings of babies were undertaken in a discreet and personal way. If appropriate, babies could be placed in a Moses basket or bassinet and brought into dedicated family rooms to enable parents to view their baby in homely environment. This was responsive to parents' needs in this situation. The service produced their own booklet giving information about the end of life care services for bereavement, detailing the support offered to families by this service. This was personalised and clear for people to understand and was responsive to bereavement needs.
- In A&E, relatives could stay as long as they wished to after a patient's death. Drinks were provided and patients were not moved until the relatives were ready.
- Information leaflets about the hospital's palliative care service and about caring for the dying patient were available in a range of languages.
- The SPCT were able to meet people's needs in the hospital but they were in the process of recruiting additional staff to enable them to be more proactive in their response to patients' needs.
- Patients at the end of life would be cared for, where possible, in individual side rooms to give them more privacy.

Access and flow

- Patients were referred to the SPCT if they had been identified as requiring end of life care.
- The SPCT told us that they met each morning to review referred patients and those who required their input. They would then plan their caseloads accordingly.

- If a patient decided that they wished to die in hospital, the nurses told us they tried to keep the patient in the same bed.
- Where possible, side rooms were prioritised for patients at the end of their life. This provided privacy for patients and their families.
- There was no specified pathway for end of life care for dementia or learning disability patients.

Learning from complaints and concerns

- Information for patients and visitors about how to make a complaint was displayed on each ward and was also available on the trust's website.
- We saw trust documentation showing that, from January 2015, in response to a complaint, a registered nurse was allocated to the purple butterfly room during each shift. The nurse was required to introduce themselves to the relatives and keep them updated on the patient's care plan and treatment.
- The SPCT and ward staff said there was active reflective practice and learning following complaints and improvements had been made in facilitating timely patient discharge from hospital as a result.

Are end of life care services well-led?

Good



The end of life care service was well-led.

There was a vision and strategy for the end of life care service. An increase in investment and staffing had been made to support a seven-day, face-to-face service by the SPCT. The trust had a specialist palliative care clinical governance group that provided a forum for clinical governance development, implementation and monitoring across the hospital's specialist palliative care services. An identified executive director was the lead for end of life care.

The trust engaged with stakeholders and clinical commissioning groups (CCGs) through bi-monthly strategy meetings whose membership included a CCG representative.

End of life care

Risk management and quality assurance processes were in place at a local level. The end of life service held governance and patient safety meetings. Records showed that risks were escalated and had been included on risk registers and were monitored each month.

Team working on the wards between staff of different disciplines and grades was good.

Staff in the SPCT spoke positively about the service they provided for patients and were passionate about their work. The mortuary and bereavement staff culture was very positive and enthusiastic about the provision of care at the end of a person's life. This was demonstrated and evidenced through their approach to patient care.

The trust did not have specific consultation groups for patients and the public to contribute to the development of end of life care services.

The SPCT acknowledged that there was work to be done to improve end of life care services throughout the trust and had compiled a five-year plan to address this.

Vision and strategy for this service

- There was a vision and strategy for end of life care.
- We saw documentation entitled The Rotherham NHS Foundation Trust 5 Year Strategy for End of Life Care which followed the One Chance to Get it Right guidance from the Leadership Alliance for the Care of Dying People. There was an increase in investment and staff to support a seven-day, face-to-face service by the SPCT.

Governance, risk management and quality measurement

- The trust's specialist palliative care clinical governance group provided a forum for clinical governance development, implementation and monitoring across the hospital's specialist palliative care services.
- The trust engaged with stakeholders and CCGs through a bi-monthly strategy meeting whose membership included a CCG representative.
- Risk management and quality assurance processes were in place at a local level. The end of life service held governance and patient safety meetings and records showed that risks were escalated and had been included on risk registers and were monitored each month.
- We found that managers were aware of the quality issues affecting their services and shared this with staff.

Leadership of service

- An identified executive director was the lead for end of life care.
- Most staff said they were aware of the leadership structures and received good leadership and support from their immediate line managers.
- Staff confirmed that there were regular formal 'cascade' processes for information dissemination, including messages from the chief executive and board of directors.
- Most of the staff on the wards were aware of the SPCT.
- The trust had an agreement with the hospice to ensure that end of life care support was available 24 hours a day.

Culture within the service

- Team working on the wards between staff of different disciplines and grades was good.
- Staff in the SPCT spoke positively about the service they provided for patients and were passionate about their work.
- Trust staff spoke positively about the SPCT.
- Staff told us about positive working relationships and we observed that staff were respectful towards each other, not only within their specialities, but across all disciplines.
- There was good team working between the SPCT and the bereavement service.
- The mortuary and bereavement staff culture was very positive and enthusiastic about the provision of care at the end of a person's life. This was demonstrated and evidenced through their approach to patient care.
- Most staff we spoke to said they felt confident to whistle-blow or raise concerns with their managers.
- Staff said they had regular staff meetings where concerns were raised and discussed.

Public and staff engagement

- There were no specific consultation groups for patients and the public to contribute to the development of end of life care services in the trust.




Innovation, improvement and sustainability

- The SPCT acknowledged that there was work to be done to improve end of life care services throughout the trust and had compiled a five-year plan to address this.

End of life care

- The SPCT was working towards providing a seven-day, face-to-face service.
- The trust had a new mortuary (built three years ago) which incorporated body storage facilities for the trust's and the community's deceased.
- There was good collaboration with local and national palliative care networks, including other care providers, to improve quality of care and people's experiences.
- There were two new 'purple butterfly rooms' planned for the hospital.

Outpatients and diagnostic imaging

Safe	Requires improvement	
Effective	Not sufficient evidence to rate	
Caring	Good	
Responsive	Good	
Well-led	Good	
Overall	Good	

Information about the service

The outpatients and diagnostic imaging services at Rotherham Hospital covered a wide range of specialities including dermatology, orthopaedic, ophthalmology, respiratory, and gastroenterology. Some clinics were held at venues in the community as well as neighbouring trusts. The diagnostic and imaging department carried out routine x-rays as well as more complex tests such as magnetic-resonance imaging (MRI) and computerised tomography (CT) scans. We inspected services that were solely delivered from the hospital site. Services at the hospital saw adults and children and there was a separate children outpatients department.

The main outpatients department was situated near the main entrance next to reception. Outpatient services were available Monday to Friday from 8am to 9pm and some clinics were available Saturdays between 9am and 5pm. Diagnostic imaging services were in operation seven days a week. Patients were referred by their GP, consultant's private practice or as self-referrals. The trust had a total number of 336,635 appointments in 2013/14.

Not all outpatient services were delivered under one governance structure or location within the hospital. For example, oral and maxillofacial surgery (OMFS), ear, nose and throat (ENT), dermatology, and urology were managed by different directorates and clinical leaders. OMFS and ENT clinics took place in the main outpatients department, however, dermatology and urology were delivered elsewhere in the hospital. Clinics were also delivered in the Earl of Scarborough Suite which was situated next to the main outpatients department.

We inspected the main outpatients department, the Earl of Scarborough Suite, children's outpatients and dermatology. We also inspected clinical radiology, nuclear medicine, and pathology. During our inspection we spoke to 55 members of staff, including diagnostic and imaging staff, consultants, nurses, a volunteer and support staff. We observed care, looked at 17 patient records and spoke to 47 patients and those close to them (including seven children).

Outpatients and diagnostic imaging

Summary of findings

Overall we found that the outpatients and diagnostic and imaging department was good.

There were challenges regarding medical staffing in outpatients and allied health professionals in diagnostic imaging, but plans were in place to respond accordingly. Data from the trust showed that there were low completion rates for safeguarding and mandatory training. There was little evidence that Mental Capacity Act 2005 training had taken place.

Incidents were reported and risks to patients were assessed. Processes and procedures were in place according to national guidance and regulations. Infection control and cleanliness of equipment was of a good standard.

Staff were able to demonstrate evidenced-based care and treatment, monitoring of patient outcomes and there was good multi-disciplinary working. Staff were caring and we saw positive interactions between staff and patients. There were good initiatives and pathways for patients, and services were responsive to people's needs. Referrals were managed well by booking staff, however, we saw that some patients had been waiting nearly two years for follow-up appointments. The trust assured us that patients had not come to harm as a result of these waiting times.

The environment presented significant challenges for all departments. Patient flow between departments was affected by a lack of space; some departments were located on different floors. Waiting areas were small in the main outpatients area and staff said that they had "outgrown" the space they were in. However, plans were in place to address this through the estates strategy and staff worked well and utilised the space as best they could.

Services were well-led at department level. Staff felt supported by their managers. There was a positive view of the chief executive and the majority of staff shared managers' visions for the services. There was a positive culture which encouraged teamwork and collaboration. However, there were concerns about escalating issues to senior management, the level of bureaucracy and the lack of response to issues.

Are outpatient and diagnostic imaging services safe?

Requires improvement 

We rated safety in outpatients and diagnostic imaging services as requires improvement.

Mandatory and safeguarding training levels were below the trust standard, with many departments falling short of the trust targets. Staffing levels varied with a high use of bank (overtime) and agency staff in some departments as well as shortages in diagnostic and imaging highlighted on the risk register.

Risks to patients were assessed but we saw that procedures around used needles (sharps) bins were not followed. Equipment was checked on a regular basis and diagnostic and imaging services followed relevant guidelines and policy.

Incidents were reported and investigated appropriately and learning was shared. Patients were informed about incidents and were provided with copies of the reports. The environment was clean and we saw staff adhering to infection control procedures. However, the environment also presented challenged to patients and staff and this had also been highlighted on the risk register.

Incidents

- Between January and December 2014 there were two serious incidents requiring investigation. The incidents related to one screening issue and one delayed diagnosis. Investigations were ongoing at that time of our inspection. Discussions with the managers showed that they had identified the main concerns from the incidents and were putting mitigating actions into place.
- There was a good reporting culture in the outpatients and diagnostic imaging service. Staff were aware of how to record and report incidents on the trust's electronic reporting system. Staff demonstrated they were aware of what types of incidents needed to be recorded, and we saw examples on the system.
- Trusts are required to report any unnecessary exposure of radiation to patients. There were six incidents reported to the CQC under Ionising Radiation (Medical

Outpatients and diagnostic imaging

Exposure) Regulations (IR(ME)R) between January and December 2014. There was evidence that the incidents had been investigated and actions implemented as a result of learning.

- Examples of serious incident reports showed that incidents were investigated appropriately and the relevant staff were involved. Actions and learning were identified and shared through appropriate channels and we saw evidence of this in team meetings. There were actions plans in place to ensure that learning was implemented across departments. Senior nursing and imaging staff described how individual learning from complaints happened in team meetings, one-to-ones and appraisals with staff.
- Nursing staff were aware of the Duty of Candour regulations and explained that patients and those close to them were informed when incidents were reported. Copies of the serious incident investigation report were sent to patients and/or their families once investigations were completed. This was in line with the trust's 'Being Open' policy.

Cleanliness, infection control and hygiene

- The trust policy was for all staff to be 'bare below the elbows' in clinical areas and to wash their hands before treating patients. Monthly audits were conducted to make sure staff complied with both of these practices. Data for March to November 2014 showed that nursing and medical staff were fully compliant (scoring 100%) with the policy in outpatient departments. We saw that all staff were bare below the elbows in clinical areas. This reduced the risk of infections to staff and patients and was in line with national good hygiene practice.
- Waiting and clinical areas were visibly clean. We saw that treatment rooms and equipment in outpatient areas were cleaned regularly. Toys and equipment in the children's waiting areas were cleaned weekly. Imaging equipment was cleaned and checked regularly. Rooms used for diagnostic imaging were decontaminated and cleaned after use. Processes were in place to ensure that equipment and clinical areas were cleaned and checked regularly. The trust conducted cleaning audits to ensure that all areas had been checked and cleaned.
- Personal protective equipment was accessible in clinical areas and we saw it being worn by staff when treating patients and during cleaning or decontamination procedures.

Environment and equipment

- There was resuscitation equipment readily available for staff to use if needed across outpatients and diagnostic imaging departments. This equipment was checked daily. There was also oxygen and breathing equipment on hand if a patient had breathing difficulties.
- There were radiation warning signs outside any areas that were used for diagnostic imaging. Preparation of radioactive materials were done behind keypad coded locked doors to ensure safety. However, in the nuclear medicine reception area, we saw a ceiling tile dislodged, exposing a roof void and electrical wiring. Managers reported this immediately.
- The environment and location of the main outpatients and diagnostic imaging departments presented challenges for patients and staff. During busy periods, there were queues of patients waiting to be booked-in for their appointments at reception desks. This made corridors very busy and we saw patients and staff struggling to walk down corridors. We observed a queue at ophthalmology reception which had restricted access to a minor operations theatre. This had also been highlighted on the corporate risk register where the risk of slips, trips, and falls had been noted.
- In six treatment rooms across the Earl of Scarborough Suite and main outpatients, we saw that sharps boxes (filled with used needles and other sharp medical instruments) were open and not secure as per the trust policy. We were told that the boxes were not in use, however, the trust sharps policy stated that "when not in use the aperture must be closed." We informed senior nursing who addressed this immediately.
- All staff we spoke to had received fire safety training and were aware of what to do in an emergency. There were two different exits out of the department and doors that joined on to other clinical areas to ensure that patients were able to leave departments in an emergency.
- All electrical equipment we checked had been portable appliance tested (PAT) for safe use. We saw rotas and processes to ensure that equipment was checked or maintained on a regular basis.
- Staff wore dosimeters in radiology to ensure that they were not exposed to high levels of radiation.
- The radiology department was clean with plenty of room for patients and staff to move around. There was a

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television and patients found the environments comfortable. Patients described the environments as “pleasant” and all the patients we spoke to liked the waiting area.

- Management staff felt that improvement was sometimes hindered. For example, there were concerns that requests for equipment funding took too long to be agreed, especially when needed immediately. Staff described a process where funding could not be agreed outside the business planning process and therefore staff had to wait until it started in January. This meant that there were delays to buying equipment needed for services.
- Quality assurance checks were in place for equipment in diagnostic imaging. These were mandatory checks based on Ionising Radiation Regulations 1999 and IR(ME)R 2000. These protect patients against unnecessary exposure to harmful radiation.
- We saw that quality assurance checks for fluoroscopy and x-ray equipment had taken place. This demonstrated that the use of radiation was being checked on a regular basis.

Medicines

- We checked the storage and management of medicines and found effective systems in place. Refrigerator temperatures were monitored, with the exception of one fridge in the Earl of Scarborough Suite where a thermometer had broken. This meant that checks could not take place to ensure that medicines were stored at the appropriate temperature. The lead nurse for outpatients reported the incident through the incident reporting system and the thermometer was replaced the same day. The medicines were disposed of.
- Drugs and lotions were stored safely and all medicine cupboards we checked were locked. All medicines we checked were within their expiry date.
- Staff were aware of the trust’s medicines management policy and it was available in departments for staff to refer to.
- The preparation of radioactive injections was conducted in separate, locked preparation areas. Doors were locked, with key-pad code entry only, and the preparation areas were clean and tidy.

Records

- We viewed 17 patient records and there was a good standard of record-keeping. Notes were signed, dated, and timed as per the trust policy. The majority of notes were legible, however, despite notes being signed, there was not a printed name to accompany the signature. This meant that it would be difficult to identify who entered the notes unless staff were familiar with a signature. This was not in line with trust standards.
- The trust has implemented an electronic patient record system to replace paper medical records. Staff were unhappy with the electronic system. Medical staff described how it was not fit for purpose – for example, ophthalmology consultants needed to draw pictures of eyes and this function could not be done electronically; paper records had to be used for drawing, while notes were typed on to the system. This meant that staff were commonly using two different record formats. One consultant described having to “work for the system rather than the system working for staff”. There was an action plan in place to improve the electronic system, including making paper records available on the system too.
- The trust conducted audits on how quickly medical records were available to clinics. A new system had been introduced for filing paper records which meant that medical records could be filed and retrieved quicker for clinics.
- There were examples of medical records not being stored securely. In ophthalmology, patient records for clinics were stored in a trolley. The trolley was used to prop open the door to the reception desk, meaning that the records were available and in public view for anyone to take away. The reception area was small and cluttered there was little space for storing the trolley inside reception. However there was a lockable cupboard inside reception which was left open. This contained patient records for that day's clinics. We saw a number of staff walk in and out of reception to take the records from the cupboard. Any non-authorised person could have done the same.
- We noticed in two other areas that medical records were kept in trolleys behind the reception desks. There were lockable cupboards for medical records storage but they were open. Despite having locks, doors to the reception desk area were both open meaning that anyone would be to access reception and take away records.
- Staff in diagnostic imaging were able to demonstrate safety mechanisms to ensure patient doses for radiation

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were recorded. Patient records were electronic and we saw these records contained patients radiology histories and treatment. The system did not allow a patient examination to be completed and a patient report produced until the patient dose was recorded. This ensured that the correct and most up-to-date information was kept on the system.

Safeguarding

- The majority of staff across outpatients and diagnostic imaging told us that they were up to date with their safeguarding training. However, data from the trust showed that most outpatient and diagnostic imaging departments did not meet the trust target of 95% for completion of safeguarding adults training. Data from the trust showed that the average completion rate across clinical departments was 7%. The trust had identified gaps in training for staff in the annual safeguarding report released in June 2014.
- Staff training rates for safeguarding children were below the trust target for most outpatient departments. The average across clinical departments was 70%, which was below the trust target of 95%.
- Only 1% of medical staff were recorded having undertaken safeguarding adults training across most clinical departments, and 25% of medical staff had undertaken safeguarding children training. This was below the trust target of 95%.
- Safeguarding information leaflets had been sent to staff with their payslips to help raise awareness of the policy and procedures. We saw that these leaflets were on staff noticeboards for reference. The trust's safeguarding policy was available in folders for staff to view. There were named safeguarding leads for outpatients and imaging departments. Staff were aware of who to escalate safeguarding concerns to.
- There were policies and procedures for assessing the risks to children. For example, if a child did not attend an outpatient clinic, the school nurse would be contacted. The school nurse would then contact the family and investigate the cause of the non-attendance and ensure that the child was safe.

Mandatory training

- The trust target for staff completing mandatory training was 95%. All staff we spoke to said that they were up to date with their mandatory training. However, data from the trust showed that the majority of outpatients departments were not meeting this target.
- Mandatory training completion rates were inconsistent across all departments. No outpatient department had met the trust target completion rate for all mandatory training courses. The average completion rate for nursing staff across all departments was 62%, with some departments performing better than others. For example, rheumatology nursing staff had a 100% completion rate for six out of nine training courses.
- The same applied to diagnostic and imaging departments. Completion rates overall were better, but still below the trust target. For example, nursing staff in radiology had a completion rate of 61%.
- The average rate for medical staff across all departments was 25%. Radiology and urology had the highest completion rates but were still below the trust target.

Assessing and responding to patient risk

- The trust had a medical physics expert available and contactable for consultation to provide advice on radiation protection for medical exposures in radiological procedures. This was in line with the IR(ME)R 2000 guidance. There were named, certified radiation protection supervisors to give advice when needed and to ensure patient safety at all times.
- Arrangements were in place for radiation risks and incidents defined within the comprehensive local rules (used to help diagnostics and imaging work to national guidance). Policies and processes were in place to identify and deal with risks. This was in accordance with IR(ME)R 2000.
- Staff asked patients if they were pregnant in the privacy of the x-ray room to preserve the privacy and dignity of the patient. This was in accordance with the radiation protection requirements and identified risks to an unborn foetus. We saw that different procedures existed for example, patients who were pregnant underwent extra checks.
- Because of the proximity of the outpatients department to reception, staff said it was common that they would

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be called in to the main reception area to deal with emergencies. Nursing staff gave us several examples and were aware of their roles and responsibilities when this happened.

- Outpatients and diagnostic imaging used early warning scores to monitor and manage patient risk. Patients were assessed and given scores to indicate how they should be managed and treated.
- If a patient deteriorated, systems were in place to contact an emergency response team. There were also a number of resuscitation trolleys available across outpatients departments.

Nursing staffing

- There were dedicated nurses and healthcare support workers available to provide services and support to clinics in the main outpatients area. In addition, there were nurses from different specialities who also worked in outpatient clinics.
- The use of agency and bank staff across outpatients varied. Data from the trust (December 2013 to November 14) showed that no bank and agency staff were used for most outpatient clinics. The use of bank and agency staff was below the England average. However, orthopaedics and outpatient nursing services required bank and agency staff to operate at safe levels. Orthopaedics required between 20% and 30% and nursing services had required 10% to 20% of nursing staff to be via the trust flexible staffing system (bank).
- We saw evidence of planned staffing for clinics. Safe staffing levels were determined by the number of consultant clinics and the needs of patients. If there were patients requiring one-to-one support or large numbers of patients expected, staffing would be allocated accordingly. Bank and agency staff were used to cover for sickness. Senior nursing staff were also able to move staff between clinics to meet demand.
- Nursing staff in dermatology expressed concerns about staffing levels. Some nurses were running their own clinics while support staff were assisting consultants in their clinic. Data from the trust showed that, between January and September 2014, bank and agency staffing levels for dermatology were between 70% and 100%. The high use of bank staff was because the trust were running additional dermatology clinics.
- There were staff vacancies in diagnostic and imaging. A radiographer stated that current staffing levels could cover planned rotas but unplanned sickness depleted

numbers to potentially unsafe levels. Some staff voiced concerns over staffing issues. Staffing was highlighted on the risk register and there were plans to recruit to the vacancies in March 2015. There were also plans to bring in agency workers to help fill gaps.

Medical staffing

- There was a shortage of consultants employed by the trust in outpatients departments. The trust used locum medical staff to ensure that there were enough doctors to look after patients and cover clinics. Data provided by the trust showed that, in rheumatology, 25% of medical staff were locums. Gastroenterology, haematology, and dermatology used locums to cover for vacancies. The trust told us that these posts were being recruited to.
- Obstetrics and gynaecology clinics did not use bank and agency for outpatient clinical activity. All outpatient clinics were run by substantive medical staff.
- There was a shortage of sonographer staff in diagnostics and imaging. There were vacancies of 4.85 whole time equivalent (WTE) posts. There were five staff, including locum cover, for a number of areas requiring radiologists. There had been a loss of scanning capacity from consultant obstetricians, job plan revisions and maternity leave. This meant that medical staff in this area were under pressure. The trust said that shortlisting had taken place and they would be recruiting to posts in three to four months.

Major incident awareness and training

- The trust had a major incident plan. The plan took in to account national (such as an outbreak of diseases) and local emergencies (a major road transport accident) and what actions staff should take. As part of the plan, outpatients and imaging departments had an action cardholder - an allocated person responsible for ensuring that they have read the plan and understand the processes for their department.
- Staff were aware of the hospital's major incident plan and of who their action cardholders were. Staff understood what actions to take in the event of an incident such as a fire. The trust had recently sent information to staff on what to do in case of an Ebola outbreak.

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Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Diagnostic imaging services demonstrated evidenced-based care and treatment in accordance with national and local guidelines. There were procedures to manage any patients in pain. The majority of staff had received appraisals and competency frameworks were in place for staff.

We saw good multidisciplinary team working and diagnostic and imaging services had moved to seven-day working. Outpatient departments provided clinics on a Saturday. There were processes in place to ensure that staff had the right access to information. Staff understood their role and duties around consent, however, there were inconsistent levels of Mental Capacity Act 2005 training for staff.

Evidence-based care and treatment

- Diagnostics and imaging had produced action plans based on audits against National Institute for Health and Care Excellence (NICE) guidance. For example, NICE guidance CG114 for venous thromboembolic diseases which helped inform the diagnostic pathway and meant that patients were booked-in for the right scan at the right time.
- Diagnostics and imaging conducted patient dose assessments and audits to ensure that patients received the correct level of radiation dose when receiving x-rays. Part of this work used national guidelines to inform practice.
- Diagnostic imaging services used the World Health Organization (WHO) surgical safety checklist for patients who were undergoing treatment. This was usually used in a surgical environment but was modified to suit diagnostic and imaging services. The trust conducted an audit of the use of this checklist and were found to be 100% compliant. This meant that patient risk was assessed before undergoing image-guided procedures.
- We saw reviews against IR(ME)R regulations and learning disseminated to staff through team meetings and trainings. This included auditing request cards and checking whether female patients were pregnant or breast feeding. We saw audit evidence provided by the

trust which showed that diagnostics and imaging were 92% compliant with this rule. Learning and investigation had taken place where this requirement had not been met.

- Outpatients department audited medical documentation to ensure that the correct information was available and procedures were followed by nursing and medical staff. We saw audits for ophthalmology, rheumatology, dermatology and ENT. Results showed that there had been a drop in standards between 2012 and 2014 against the trust policy. Identification of the main issues had taken place and staff had received presentations and briefings on notes. We saw, in the majority of medical notes, that there were improvements against the standards.
- The trust had a radiation safety policy in accordance with national guidance and legislation. The purpose of the policy was to set down the responsibilities and duties of designated committees and individuals. This was to ensure that all work with ionising radiation undertaken in the trust was as safe as possible.
- The trust had a radiation protection supervisor to lead on the development, implementation, monitoring and review of the policy and procedures to comply with IR(ME)R guidance.
- The ENT service in outpatients had policy and procedures based on guidelines from ENT UK and NICE. A review of the care received by patients who had tracheostomy, reported as On the Right Trach, had been used to influence practice in tracheostomy insertion such as tube sizing, cannula insertion, and cleaning.

Pain relief

- Most patients who attended outpatient clinics had already received or were using pain relief. However, there were procedures in place if patients were in pain. Local anaesthetic was available for any minor operations that took place in the main outpatients department. There were also nurse prescribers which meant that patients did not have to wait for consultants for prescribed medication. If patients attended appointments in severe pain, the outpatients department could access the hospital acute pain team.

Patient outcomes

- The diagnostic and imaging department had taken part in audits to assess the impact of imaging on patients. For example, audits had been undertaken for patients

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who presented with chronic obstructive pulmonary disease (COPD) and non-traumatic abdominal pain. The aim was to identify best practice when conducting diagnostic testing so that patients received a more accurate diagnosis of their conditions.

- After receiving care and treatment, patients were either given another appointment or provided with information about the partial booking process (for example, six-monthly or annual reviews). Consultants decided on whether a patient required a follow-up appointment. If not, the outpatient episode was complete. This was in accordance with the trust policy and administration staff were able to describe this process.
- For July 2013 to June 2014 the trust's ratio of follow-up appointments to new appointments was close to the England average, and similar to the average rates for other trusts. The national rate was in the range of 2:2 to 2:3. The trust's rate was in the range of 2:3 to 2:6. This 'follow-up to new' rate was at its lowest level in June 2014.
- The main outpatients department used a haematology outcome slip to monitor outcomes for waiting times, treatments, follow-ups and discharges. This enabled the clinic to improve their services and monitor trends in patient care and treatment.

Competent staff

- The majority of nursing staff (94%), radiology staff (96%) and healthcare support staff (92%) had received appraisals as of November 2014. During the same period, 86% of administrative staff working across outpatient and diagnostic imaging departments had received appraisals. We saw in training records that appraisals for staff were up to date.
- Staff told us they had received appraisals and personal development reviews. Staff learning and development needs were identified once a year through this process. Staff told us that they were able to access training to meet their learning needs and were encouraged to find opportunities to develop. Senior nursing staff were positive about developing their staff teams.
- There were no established models of regular clinical supervision (which allows staff to reflect on and review their practice in a safe environment). Nursing and non-nursing staff told us that they did not receive clinical supervisions but that they would like to. We spoke to senior nursing staff who said they provided

clinical supervisions when it was needed. One senior nurse said that developing a regular clinical supervision programme was a target in her latest appraisal. Regular clinical supervisions would enable staff to change and improve practice by identifying training and development needs.

- We saw competency frameworks for new nursing staff and healthcare support workers. The frameworks identified the minimum standard and specialist knowledge that staff required to undertake their role. There were competency frameworks in place for a variety of clinical specialisms, including cardiology, ENT, and rheumatology.
- Medical staff said that they were up to date with their appraisals and were given time for personal development.

Multidisciplinary working

- There were multidisciplinary team meetings for different clinic specialities such as dermatology, lung and breast services. We observed the lung multidisciplinary team meeting which took in to account patient background and choices for treatment, and we saw that those wishes were respected. There was healthy challenge and discussion between medical staff about diagnosis and treatment, with actions identified for treatment and ways forward. It was noted that these discussions always centred on what was better for the patient. The chair of the multidisciplinary team ensured that everyone agreed the actions before proceeding. Patients who were to receive bad news were noted so that arrangements could be made to support them.
- The Earl of Scarborough Suite had a central room which acted as a hub for consultants and nurses to work from. The room was busy and well-used and we saw nurses, healthcare support workers and consultants discussing patients and actions.
- Rotherham Metropolitan Borough Council commissioned an eye clinic liaison officer post from the charity Action for Blind People. Patients were assessed to see if they had dual sensory loss, in which case the eye clinic liaison officer referred them to the council's dual sensory loss team. The officer also referred patients to services which were able to assist them, such as the independent living coordinator employed by Action for Blind People or the council's visual impairment team.

Seven-day services

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- Diagnostic imaging provided services seven days a week. Outpatient services were available Monday to Friday from 8am to 9pm and some clinics were available on Saturdays between 9am and 5pm. Pathology delivered out-of-hours services for clinical testing such as blood tests.

Access to information

- Diagnostic imaging departments had a picture archive communication system and radiology information system that stored images, radiation doses and patient reports. Staff were trained in these systems and were able to access patient information quickly and easily.
- There were systems to highlight urgent, unexpected findings to GPs and consultants. This was in accordance with the Royal College of Radiologists guidelines and involved sending reports directly to the GP's or consultant's secretary. A checking and alerting system was in place on the picture archive communication system to make sure that documents had been sent. This helped to minimise any human error and keep track of reports sent to consultants and GPs.
- Systems and processes were in place if patient records were not available at the time of appointment. Temporary notes would be created, and referral and discharge letters were stored electronically so they could be printed off and added to the notes.
- There were processes for accessing patient files and information. Staff used an electronic system which contained patient record details, supplemented by the use of paper-based patient notes where electronic files were not available.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Nursing, imaging, and medical staff understood their roles and responsibility regarding consent. We were given examples where this had happened. Most patients told us that staff had asked for consent before undertaking any examinations or procedures. We saw in medical records that, where consent was required, it had been written in the patients' notes.
- Senior nursing staff told us they had completed their Mental Capacity Act 2005 training. However, training for staff had not been rolled-out. Some learning had taken place at outpatient team meetings which had been delivered by senior nursing staff. Information leaflets on the Act and its associated deprivation of liberty

safeguards were sent to staff with their payslips. Staff signed a form to say they had received the leaflet, however, there was no way of telling whether staff had read or understood the information.

- Medical staffing said that they were aware of the Mental Capacity Act, however, there had been little or no training. A senior member of imaging staff said that training in the Act had not yet been "fully embraced" and ways of rolling out training were being discussed.

Are outpatient and diagnostic imaging services caring?

Good

Diagnostic and imaging services were caring. We observed positive interactions between staff and patients. Staff were patient-focused and kept patients informed and involved. Patients' privacy and dignity were respected by staff, and patients were positive about their treatment and care.

However, response rates for the NHS Friends and Family Test were worse than the England average and there was an inconsistent approach to handing out the test questionnaires.

Compassionate care

- Staff in outpatients and diagnostic imaging were caring and compassionate to patients. We observed positive interactions with patients including a healthcare support worker helping a patient out of a wheelchair and supporting them to walk. Staff approached patients and introduced themselves. Patients said that staff were friendly, kind and caring. Patients were comfortable talking with staff.
- There were good interactions between patients and reception staff. We saw one reception staff ask how a patient was feeling after they had come into the clinic feeling unwell. Another member of reception staff was proactive in establishing why a patient had to wait a long time to see a consultant. The member of staff kept the patient informed at all times. Reception staff told us they felt that their job was much more than being on the front desk.
- Patients' privacy and dignity were respected by staff. We saw the use of privacy screens and curtains. Treatment rooms had privacy curtains and locks on the door so

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that patients could get changed before seeing a clinician. A patient said that staff were “very good” at preserving their privacy and dignity. Another patient said that staff always pulled curtains across and ensured that doors were closed in treatment rooms.

- There were separate toilets and waiting areas for patients who had received radioactive injections.
- The Trust used the NHS Friends and Family Test – a survey that asks patients whether they would recommend the service to friends and family who need similar treatment or care.
- The trust’s response rate for the test was 27% which is worse than the England average of 31%. We saw that patients were not handed test question cards in clinics and, when we asked patients, most of them told us they had never been given the opportunity to provide feedback. We talked to two reception staff who told us that the procedure had changed several times for handing out the test cards and that they weren’t sure when to give them out any more. We saw test cards on reception desk but saw no patients taking them.
- Outpatients departments overall received positive patient feedback from the NHS Friends and Family Test. Out of 536 responses in January 2015, 507 (95%) patients said they would be likely or very likely to recommend outpatients clinics.
- The trust was in the top 20% of hospitals for nearly half of the 34 elements of the Cancer Patient Experience Survey 2013/14. This indicated that most patients were happy with their experience of outpatient clinics.
- Patients had access to a wide range of healthcare information in leaflets and on noticeboards. There was information that explained procedures such as x-rays, about various illnesses and conditions such as arthritis, and where to go to find additional healthcare support.

Understanding and involvement of patients and those close to them

- Patients told us that they were involved in their treatment and care. Those close to patients said that they were kept informed and involved by nursing and medical staff. A partner of a patient on the Earl of Scarborough Suite said they were pleased they were kept informed in case the patient did not take in all the relevant information.

- Outpatients and diagnostic imaging staff involved patients in their treatment and care. We saw staff explaining treatment and encouraging those close to patients to support the patient.
- Patients were informed if clinics were running late. We saw staff inform patients, apologise and explain why clinics were running late.

Emotional support

- There were private rooms available for patients who had been given bad news to receive support or talk about their condition.
- Patients and those close to them told us that they were given plenty of time and not rushed when given bad news.
- There were specialist nurses available to support patients if they have been given bad news. Specialist nurses would sit and explain what would happen next for the patient.
- There was a chaplaincy service available at the trust situated near the main outpatients department. It enabled patients to seek advice and support or a quiet place to reflect. A chaplain was available at all times of the day and night. There was also a multi faith room which was available at all times.

Are outpatient and diagnostic imaging services responsive?

Good



The responsiveness of the service was good. There was a backlog of patients waiting for follow up appointments through the partial booking system. This was due to not enough slots being provided for patients waiting for follow-up appointments in some clinics. This was particularly an issue within gastroenterology. The trust assured us that patients had not come to harm as a result of these waiting times.

We saw that new appointments were managed well by booking clerks for both paper and electronic referrals. Waiting lists were managed on a chronological basis to ensure referral-to-treatment times were met.

Service planning and delivery to meet the needs of local people

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- Cancellation figures were better than the national average for appointments. The national average for patient and hospital cancellations was 6%. The hospital had recorded a small number of hospital and patient cancellations.
- Some teams such as the head and neck team, met each morning at the beginning of shift to plan for the rest of the day. The lead nurse for this team said that 13 to 14 staff (nursing and non-nursing) met each morning to discuss staffing, patients and duties. Staff were organised and knew their roles and responsibilities.
- There were water fountains in patient waiting areas but no tea or coffee machine. The main outpatients department was situated next to the main reception area where there were facilities to purchase food and drinks. However, patients risked missing being called for their appointment if they used these facilities. It was also difficult for patients with mobility issues.
- Managers and senior outpatients and diagnostic imaging staff were aware that the space did not meet the demands of patient need. We were told that many departments had “outgrown” the space they had been working in. There were plans to move several departments to try and integrate services as part of the estates strategy. Services and staff did what they could with the space they had available to meet the patients' needs.
- Extra clinics were provided at weekends to meet demand. For example, ophthalmology clinics were provided on a Saturday due to increased numbers of patients.
- Some patient waiting areas were situated in main corridors. Therefore, at busy times there were raised noise levels and those patients queuing to book in were in close proximity to those seated and waiting. A consultant said that “space was hard to come by” in terms of meeting the needs of the service and patients.
- There was a rapid access clinic for children’s outpatients. Children were seen within 48 hours of a referral. Staff told us that there were four slots per session and if oversubscribed children would be redirected to triage and seen on the children’s ward.
- There were designated areas for children to play and wait for appointments. Within children’s outpatients there was a day room for children to wait with their parents. We observed that it was well used by families.

The day room had toys and was staffed by a nursery nurse who entertained and played with the children. Parents commented that it was a nice area to wait for appointments.

- In main outpatients there was a smaller unstaffed playroom which needed better resources. Parents commented that it was too small, even for only three or four small children and two adults. We looked in the playroom and saw a limited number of toys suitable for very young children. Walls were sparsely decorated and there were two chairs for adults. Nursing staff told us that they wanted better facilities but were restricted by the space they had to work with.

Access and flow

- Booking patients in to clinics was performed in different ways, depending on the type of clinic. The majority of clinics were booked through clerks working in the access centre which was housed in a separate building. Appointments for clinics within children’s outpatients were booked by consultant’s clerical assistants.
- National guidelines say that 95% of patients should start consultant-led treatment within 18 weeks of referral. Referral-to-treatment times at the trust were better than the England average, averaging 98.7% between July and December 2014. This meant that most patients were not having long waits to access treatment and care.
- The trust used the NHS Choose and Book system – a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic. We saw that GPs and patients were not always able to book through this system due to the demand for appointments.
- We saw that booking staff managed waiting lists for new and follow-up referrals (in under six weeks) ensuring that patients were allocated appointments on the basis of their referral or waiting time on the system. This also included paper referrals that had not come through via Choose and Book. Booking staff had identified and escalated a lack of capacity in clinics.
- There was a backlog of patients waiting for follow-up appointments through the partial booking system. This was due to not enough slots being provided in some clinics. This was particularly an issue within gastroenterology. There were more than 500 people waiting for appointments that were overdue. We saw that, in February 2015, 14 patients had been waiting since April 2013 for their appointments. We were

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informed that a validation process was in progress, including clinical validation where necessary. We were assured by the trust that patients had not come to harm as a result of these waiting times.

- The trust's rate for patients who did not turn up for appointments averaged between 7% and 8%. This was within 1% of the England average (between July 2013 and June 2014). For outpatients, the non-attendance rates averaged between 8% and 12% which was worse than the England average (August 2014 to January 2015) for new patients. The non-attendance rate was between 8% and 10% for follow-up patients.
- There were policies in place for non-attending patients. Booking and reception staff were able to tell us the procedure for both adults and children. Consultants determined whether patients should be offered a further appointment and letters were sent to the patient and their GP. Staff were aware of the policies and procedures and we observed they were followed.
- Children's outpatients had an initiative which had reduced non-attendance. A senior nurse told us that patients were called 24 hours before their appointment and this had reduced the non-attendance rate. The rate for non-attendance in children's outpatients had dropped from 13.9% to 6.7% between April 2014 and January 2015.
- Outpatient and imaging departments ran 'one-stop-shop' clinics where patients were able to see several clinicians during one appointment. This meant that patients did not have separate appointments to see nurses, radiographers and consultants on different days. Patients we spoke to liked this approach. In the Earl of Scarborough Suite patients would be taken to one room and visited by each relevant clinician. The lead nurse for outpatients said, "we wanted to revolve staff around patients, not patients around us".
- Data from the trust for appointment waiting times for outpatient clinics showed that 24% of patients in the main outpatients department had to wait more than 30 minutes to see a clinician (30 minutes is the operational standard for appointment waiting times). We saw long queues of patients at reception A in the main outpatients department waiting to book in on the first day of our inspection. Patients told us that they had been waiting over an hour and a half to see consultants. The trust assured us that patients had not come to harm as a result of these waiting times.
- Cancer waiting times were in line with, or better than, the national average. The percentage of people seen by a specialist within two weeks of a GP referral between July and December 2014 was in line with the national average; the overall waiting times from referral and diagnosis to treatment for all cancers were better than the national average.
- The trust's diagnostic waiting times were better than the national average. In October 2014, 99.9% of patients were seen within six weeks. We spoke to 14 patients in radiology who all said they found the referral and booking process to be quick and easy.
- There was a designated waiting room and area where patients could book and wait for patient transport in the main outpatient departments. This meant that patients with mobility difficulties did not have to go very far to book and wait for transport. Nursing staff told us that patients who required special assistance were prioritised so that they were seen quickly while ambulance crews waited.
- A member of nursing staff told us that some treatment rooms in ENT were no longer fit for purpose because of the old fixtures and fittings. We were shown the difference between new refurbished treatment rooms and two older ones. The new treatment rooms were bright, clean and modern. The older rooms had old fixtures and fittings and large wooden benches that could not be moved. This meant that staff had to arrange equipment around them, making the area more cluttered. The nurse described the older rooms as "preventing a natural flow" to treating patients because she couldn't place things where she needed them. The treatment rooms had been placed on the trust risk register.

Meeting people's individual needs

- Language translation services were available in outpatients and diagnostic imaging. Translators were arranged by the booking staff on receipt of referral. However, booking staff had to rely on GPs relaying a patient's requirements. Nursing staff told us that translators were preferred over friends and family to ensure that clinical discussions were communicated correctly.
- We saw feedback from older children from November 2014 requesting more toys and activities that were more suitable to their age. Parents said that most toys were for babies and toddlers and so older children had

Outpatients and diagnostic imaging

nothing to occupy them in the main waiting areas. We saw children of ages four and five years waiting in the main outpatients area. A child we spoke to had brought along his electronic tablet because there was nothing else to do. However, children from other families may not have had access to these items.

- The trust had leaflets designed for patients who had learning disabilities. Resources were available for staff to communicate with patients and a hospital communication book was available. There was also a leaflet for staff, providing them with a guide to meeting the needs of people with learning disabilities.
- The trust had a mechanism in place to identify and highlight patients with learning disabilities and autism. Known patients with learning disabilities had a personal plan that identified their needs. Protocols ensured that pathways of care were reasonably adjusted to meet the health needs of these patients. This was in accordance to the trust's learning disability policy.
- The trust used a "forget-me-not" dementia alert system as part of the new electronic dementia screening programme. The scheme aimed to provide extra support to individuals and their carers regardless of their condition. In radiology, patients were given a courtesy call the day before their appointment to ensure they were aware of it.
- The trust had employed a dementia care lead nurse who worked trust-wide in the hospital and community. Outpatients and diagnostic imaging had dementia champions (staff who have been trained in dementia care) so that patients living with dementia received more bespoke care and treatment. A consultant said that patients with complex needs were always known to them beforehand.
- Dementia awareness training was part of the trust's mandatory training programme. However, staff told us that dementia training as part of the mandatory e-learning was still being developed. The training rate for dementia awareness among medical and nursing staff was 1% (medical staff) and 7% (nursing staff) across clinical departments. Diagnostics and imaging and most outpatient departments recorded no attendances (0%) for dementia training.
- Alerts were added to the electronic patient record system to highlight patients who had visual or hearing impairment. There were tick-boxes at the front of patients' medical notes to identify patients who were

deaf or blind. Also, the notes allowed for requests for additional support such as sign language interpreters that enabled outpatients departments to put the right level of support in place for patients.

- Outpatient departments had specialist staff to meet the needs of particular patients. Specialist ear nurses saw patients attending the primary ear care and audiology service as outpatients. In addition, ophthalmology had a specialist nurse for macular degeneration (loss of vision caused by damage to the retina) and a cataract ophthalmic preassessment nurse. Severely deaf patients were assessed by specialist nurses using sign language, or by using external sign language interpreters or computer programmes to read typed documents.
- In addition, staff approached patients when calling them in to the clinic room rather than just calling their name. However, some patients had expressed concerns and experienced difficulties. They told us that they did not receive confirmation of interpreters being booked prior to their outpatient appointment.
- The trust had a full-time eye clinic liaison officer, based in the ophthalmic outpatient department. The officer assessed patients to determine how they were coping with their sight loss, both physically and emotionally. They referred the patient on to services which were able to assist them the most.
- The phlebotomy department, where people went to have blood tests, was on the floor above the main outpatients department. This meant that patients who required blood tests as part of their outpatients visit had to leave and go to a different department and then return, a challenge for some patients.
- However, there were staff in the main outpatients and children's outpatients departments who were trained in taking blood samples for tests. This meant that patients with complex needs and very young children were able to stay in the department instead of having to relocate to another department.
- Appointment scheduling in diagnostic imaging had been redesigned to accommodate patients with special requirements. As a result, appointment delays had reduced because more time was being allocated for patients who needed more support.

Learning from complaints and concerns

Outpatients and diagnostic imaging

- Relevant patient information was accessible on the trust's website, including the complaints policy. We also saw information posters distributed at multiple locations across the departments. Most patients we asked did not know how to make a complaint.
- The trust's standard operating procedure stated that staff must seek where possible to address concerns raised 'there and then'. Staff followed this procedure and were able to tell us what to do if a patient raised a concern.
- Complaints were reviewed and actions agreed within directorates in governance meetings. Action plans with a 'red' risk assessment were monitored at the patient experience group to ensure timely closure. Directorate reports to the patient experience group reported on actions taken in response to complaints and was shared across representatives from all directorates.
- There was learning from complaints by outpatients and diagnostic imaging services. We saw team meeting notes where complaints were discussed, actions logged, and learning shared.

Are outpatient and diagnostic imaging services well-led?

Good 

Outpatient and diagnostic imaging services were well-led. Despite challenges with delivering services, leaders had a clear vision and strategy for the service. There was confidence in the chief executive and the leadership team. Most staff we spoke with described morale as "turning a corner" and improving. There were processes in place for escalating issues.

Staff were complimentary about their lead nurses and we saw there was a good working relationship between consultants and nurses, creating a positive working environment. A variety of methods were used to engage and communicate with staff. There were some initiatives to engage patients and examples of innovation within diagnostic and imaging services.

Vision and strategy for this service

- Managers for outpatients and diagnostic imaging had clear visions on how they wanted departments to run. There was a three-year strategy for patient access which

concentrated on: appointments; using resources effectively; quality services; competent staff; and a positive patient experience. Work was ongoing to meet the aims of the strategy.

- There were clear plans to improve access and patient flow through departments as well as improve staffing levels. Lead and senior department staff were aware of and signed-up to the vision and were working closely with management to fulfil the aims.
- The trust produced a 'Quality on a Page' document, highlighting the trust's vision and mission, key performance information and what values were required from staff. The document was distributed to all teams and discussed at team meetings. We saw that it was also available in communication folders. Most staff we spoke to were aware of, and committed to, the vision and values.
- Most staff we spoke to said that they felt able to contribute to the vision and the future direction of the trust.

Governance, risk management and quality measurement

- We saw evidence of assessing and managing risk through minutes of the quality governance group meeting for the directorate of diagnostics and support – a meeting of senior managers within outpatients. Risks were escalated to the group, for example, ordering and supplying additional resuscitation equipment. Risk registers were visible and available for outpatient and diagnostic imaging department staff to view.
- Medical staff told us they were able to escalate issues to management. One consultant told us they had raised the issue about lack of time off for associate specialists after being on call during the night. As a result, management agreed to give associate specialists time off after being on call the night before.
- There were patient access governance meetings to discuss and present findings of audits. These were regular meetings to discuss risks, quality of service, and to allow lessons learned from any errors or near misses. The clinical governance meetings had been recently established and were not yet fully embedded.
- There was a clear process for escalating issues to the diagnostics and support governance meetings.

Leadership of service

Outpatients and diagnostic imaging

- Most nursing staff said that managers were supportive and appreciative of their work.
- Medical staff told us that the chief executive was visible. Staff had the opportunity to attend the monthly consultant meetings with the chief executive. They thought the chief executive was doing a good job and were confident in the leadership.
- Dermatology and the main outpatients departments were without a matron. In main outpatients this was due to the directorate structure, however, there was a matron vacancy in dermatology. Lead nurses were delivering this aspect of service as well other duties such as providing clinic cover for staff. This meant there was no immediate person to escalate clinical concerns to.
- There was good leadership at department level. Lead nurses were visible and covered clinics for staff sickness or leave. Lead nurses were passionate about their role and staff felt supported by the lead nurses.
- Diagnostic and imaging services had good leadership. Staff and managers felt supported in their roles. Managers were visible and staff said that they were approachable. We observed good, positive and professional interactions between staff and managers.

Culture within the service

- Staff were proud to work at the hospital. They were passionate about their patients and felt that they did a good job. Staff in all the outpatient and diagnostic imaging departments said that they felt part of a team and empowered to do the job. Most staff we spoke to said morale was good, they were proud of their team and said there was positive team working.
- Staff told us that they felt there was a culture of staff development. A senior nurse described how they had helped a receptionist train to move in to a healthcare assistant role because of their passion for the job. Nursing staff told us that they had been given opportunities to train and develop into higher-level roles.
- Medical staff said that there was a good, supportive culture.
- Were told by outpatients and diagnostic imaging staff that there was a good working relationship between all levels of staff. We saw that there was a positive, friendly but professional working relationship between consultants, nurses and healthcare staff.

Public and staff engagement

- There was an inconsistent approach to team meetings within all the areas we visited. Nursing staff in children's outpatients described meeting every two months as a team and staff were positive about their staff meetings. However, other staff said that they were not kept informed.
- We observed a morning radiology handover meeting. Staffing requirements for the day were discussed.
- We saw evidence of team meeting minutes from the ophthalmology/head and neck team meeting. Information was shared with staff on how the department was progressing against targets and staff were praised for their efforts after a busy period in October 2014.
- Outpatient and diagnostic imaging departments had communication books. Staff could access these books to keep up to date with news, performance and feedback from patients. These were updated and used on a regular basis by lead radiographers and nurses.
- The breast clinic was trialling a privacy and dignity audit tool to ensure that patients were happy with care given and had the opportunity to provide feedback. The tool has an observational framework and a series of questions for patients to answer on their experience. Results from the audit would be reported back to the breast focus group. Patients, nurses and consultants attended the focus group to look at feedback and develop services accordingly. The trial had been running for only a month at the time of our visit, so there was no evidence yet of any improvement in services.

Innovation, improvement and sustainability

- Diagnostic imaging services were innovative. We saw a number of services and pathways that were under development to improve services for patients. An example was the single image viewer. Work was in progress to produce a single viewing portal for the trust. This allowed imaging from multiple areas of the trust (radiology and cardiology in the first wave) to be integrated together for the first time, allowing them and their respective patient reports to be available in one area.

Outstanding practice and areas for improvement

Outstanding practice

BreathingSpace was an innovative nurse-led unit. The unit had been visited by members of parliament as well as interested parties from across the UK, Japan, China and Belgium. The nurse consultant who led the unit had presented papers at national and international conferences focused on respiratory illnesses.

BreathingSpace provided exemplary care to the patients it cared for due to the highly skilled and knowledgeable staff working on the unit. Staff were caring and

compassionate and continued their caring role by supporting families after the loss of a loved one. It was an example of an innovative community service that met the needs of the population very well.

The trust hosted a photophoresis treatment service which helped patients with conditions where the white blood cells are thought to be the cause of the disease. It is the largest centre outside of London to provide the treatment. We saw a child who had travelled some distance for the treatment during our visit. It was a service that was highly valued by the patients who used it.

Areas for improvement

Action the hospital **MUST** take to improve

Ensure all staff have received appropriate training and development. This should include, mental capacity, safeguarding adults and children, resuscitation and living with dementia awareness

- Ensure all staff are able to assess the capacity and best interests of patients in line with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS).
- Ensure all DNA CPR forms are completed in line with the trusts policy and patient's capacity is assessed in line with the requirements of the Mental Capacity Act (2005).
- Ensure the number of mixed sex accommodation breaches is significantly reduced or eliminated.
- Ensure patients records are kept securely at all times.
- Ensure there are sufficient appropriately skilled and experienced staff on duty to meet the needs of all patients.
- Ensure the outpatient appointment validation process for patients waiting over 52 weeks is completed, and actions taken to assess clinical risks to patients of having overdue appointments.
- Ensure the ward environment is safe and appropriate for children and young people.
- Ensure they report and investigate incidents in timely manner and ensure learning is shared with all staff.

- Ensure the directorate risk registers are reviewed so they reflect the current identified risks, they contain appropriate mitigating actions and the risks are monitored and reviewed at appropriate intervals.
- Ensure a review of their internal safeguarding processes is carried out and identified actions are implemented.
- Ensure the transition arrangements for children and young people are reviewed.
- Ensure the leadership of the service is reviewed so there is access to senior children's nursing advice.

Action the hospital **SHOULD** take to improve

Emergency department

- Ensure a review of staffing levels is completed so appropriate numbers of suitably qualified nurses, emergency department assistants, and health care assistants on duty to manage surges in demand.
- Ensure all staff are able to attend regular staff meetings.
- Ensure there are systems in place that allow for professional sign language interpretation of consultations for profoundly deaf patients who use sign language. These could be either in-person or through a video link

Surgery

Outstanding practice and areas for improvement

- Ensure they improve the 18 week referral to treatment targets so that patients have access to timely care and treatment.
- Ensure the access and flow for patients attending fracture clinic appointments is improved.
- Ensure the movement of patients from other specialities onto surgical wards is minimised, particularly those wards providing elective orthopaedic surgery.

Critical care

- Ensure staff have access to up to date, evidence based guidance
- Ensure the access the intensive care unit is reviewed so the unit is secure at all times.
- Ensure consultant ward rounds take place in accordance with national guidance

Maternity

- Ensure guidance is reviewed so that the time intervals for recording patient observations is sufficiently frequent to ensure patient safety.
- Ensure suitably trained staff are available to provide recovery care for women post-operatively.
- Ensure documentation is reviewed so that appropriate prompts are available to identify patient safety needs
- Ensure the process for women who had social service involvement, had delivered their baby and may require an extended stay on the ward. Is reviewed.
- Ensure a review the rates of elective caesarean section and those performed following an induction of labour is carried out and any identified learning is implemented.

- Review access and patient flow on the labour and post-natal wards so there is effective use of resources and mothers and babies are cared for in the most appropriate place.

Children and Young People

- Ensure a review of their internal safeguarding processes is carried out and identified actions are implemented.
- Ensure the transition arrangements for children and young people are reviewed.
- Ensure the leadership of the service is reviewed so there is access to senior children's nursing advice.

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- Ensure sharps are managed in a manner which protects staff and patients from the risk of needle-stick injuries.

Hospital wide

- Ensure information about how to make a complaint or leave a comment is available in alternative formats and languages.
- Ensure nursing staff have access to clinical supervision.
- Ensure patients who are living dementia and/or their relatives have the opportunity to give information about their personal circumstances, their preferences and likes and dislikes.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity

Diagnostic and screening procedures
Family planning services
Maternity and midwifery services
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff
The registered person must ensure there are suitable arrangements in place to ensure staff working in the medicine, maternity, children's and young people, critical care and accident and emergency services receive appropriate training. this must include safeguarding adults and children, resuscitation and mental capacity act awareness.

Regulated activity

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment
The registered person must ensure there are suitable arrangements in place for establishing and acting in accordance with the best interests of patients without the capacity to give consent. this should be in line with the Mental Capacity Act (2005).

Regulated activity

Diagnostic and screening procedures
Maternity and midwifery services
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing
The registered person must ensure there are sufficient numbers of suitably skilled, qualified and experienced staff.

Regulated activity

Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation 18 HSCA 2008 (Regulated Activities) Regulations
2010 Consent to care and treatment

The registered person must ensure all do not attempt cardio-pulmonary resuscitation (DNA CPR) forms are completed in line with the trust's policy and that patients' capacity is assessed in line with the requirements of the Mental Capacity Act (2005).

Regulated activity

Regulation

Diagnostic and screening procedures
Surgical procedures
Treatment of disease, disorder or injury

Regulation 17 HSCA 2008 (Regulated Activities) Regulations
2010 Respecting and involving people who use services

The registered person must ensure patients are not cared for in mixed sex wards/departments apart from those areas which are exempt from meeting the national requirements.

Regulated activity

Regulation

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation 9 HSCA 2008 (Regulated Activities) Regulations
2010 Care and welfare of people who use services

The registered person must ensure the outpatient appointment validation process is completed and appropriate actions are taken to assess the clinical risks to patients from having overdue appointments.

Regulated activity

Regulation

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation 15 HSCA 2008 (Regulated Activities) Regulations
2010 Safety and suitability of premises

The registered person must ensure the environmental risks on the children's ward are assessed and mitigated so that it is safe and secure.

This section is primarily information for the provider

Requirement notices

Regulated activity

Diagnostic and screening procedures
Maternity and midwifery services
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision

The registered person must ensure all incidents are reported and investigated in a timely manner and that learning is shared with all relevant staff.

Regulated activity

Diagnostic and screening procedures
Maternity and midwifery services
Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision

The registered person must ensure all directorate and corporate risk registers are reviewed so they reflect the current identified risks, contain appropriate mitigating actions and that the risks are monitored and reviewed at appropriate intervals.