Care Quality Commission

Sheffield Teaching Hospitals NHS Foundation Trust

Inspection report

Northern General Hospital
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Date of inspection visit: 20-22 September 2022
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Ratings

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

Our findings

Our reports

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

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

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

Overall summary

What we found

Overall trust

Sheffield Teaching Hospitals NHS Foundation Trust provides acute and community health services to a population of 640,000 people in Sheffield and the surrounding areas. The trust provides specialist services for the populations of Yorkshire & Humber, parts of Mid-Yorkshire and North Derbyshire. The trust delivers services from sixteen locations:

- Beech Hill
- Central Health Clinic
- Firth Park Clinic
- Heeley Dental Clinic
- Jessop Wing
- Jordanthorpe Health Centre
- Limbrick Dental Clinic
- Manor Clinic
- Norfolk Park Dental Clinic
- Northern General Hospital
- Royal Hallamshire Hospital
- Sheffield Dialysis Unit
- Talbot Dental Clinic
- The Charles Clifford Dental Hospital
- Weston Park Hospital
- Wheata Place Dental Clinic

Our findings

We carried out this unannounced inspection of six of the acute services provided by this trust to check that the trust had made improvements since our last inspection.

We looked at all key lines of enquiry in the core services we inspected. We checked that the trust had taken action to comply with the Warning Notice we served under Section 29A of the Health and Social Care Act following the last inspection which told the trust to make significant improvements in the quality of healthcare provided. We also carried out an inspection of the well-led question which focussed on the specific areas of concern for the trust overall which were identified in the Warning Notice.

We inspected the trust's medical wards (including services for older people) and surgery at the Royal Hallamshire Hospital and Northern General Hospital. We inspected urgent and emergency care at Northern General Hospital and maternity services at the Jessop Wing.

We did not inspect services provided by the trust which were not cited as a concern in the Warning Notice we served following our last inspection. We are monitoring the progress of improvements to all of the trust's services and will re-inspect them as appropriate.

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

- There was further improvement required to ensure services were consistently safe. In surgery and medicine, the trust had not identified and addressed environmental risks including risks presented through unsafe storage of equipment, cleaning supplies and medical gases. Equipment was not clearly identified as being clean or appropriately maintained and serviced. In surgery, the trust had continued to experience never events and had not implemented a consistent approach to ensure staff learn and share lessons learnt from these incidents. In urgent and emergency services, intentional rounding was not always recorded and did not always occur with the consistency required.
- The trust had not trained sufficient numbers of staff to ensure physical restraint was undertaken safely and appropriately. The trust continued to rely on untrained staff to restrain patients when needed. Staff did not consistently undertake and record the required physical health monitoring after administering rapid tranquilisation to keep patients safe.
- There continued to be inconsistencies in practice in relation to the Mental Capacity Act. In medicine, patients subject to the Deprivation of Liberty Safeguards did not always have a recorded capacity assessment and/or decision recorded in their best interest.
- The trust did not always provide care which was responsive to the needs of people who used services. People could not always access services when they needed them and receive the right care promptly.
- There remained risks in services which had not been identified. In some instances we found leaders had not acted to reduce the impact of risks, and risks were not always reviewed in a timely manner. The trust had not made significant improvement in identifying and reporting serious incidents. There remained a backlog of serious incidents requiring investigation.

However:

- Although there was more to do to sustain and embed improvements, the trust had complied with the requirements of the Section 29A Warning Notice by making significant improvements in the quality of healthcare provided to people who used services within the timeframe specified by our notice.

Our findings

- Our overall rating for safe improved from inadequate to requires improvement. Our overall ratings for effective and caring improved from requires improvement to good. Whilst our rating of well-led stayed the same because we did not undertake a full review of the well-led key question, we found some improvements since our last inspection.
- The improvements we found meant that none of the trust's services were now rated as inadequate for safe, effective, caring, responsive or well-led. Our ratings for urgent and emergency care, medicine at Royal Hallamshire Hospital and maternity at Jessop Wing improved from inadequate to requires improvement. Our ratings for effective and caring improved in several services from inadequate or requires improvement to good.
- In rating the trust, we took into account the current ratings of critical care, end of life, outpatients. community services including community nursing, end of life, dental and services delivered at Beech Hill, Sheffield Dialysis Unit, The Charles Clifford Dental Hospital and Weston Park Hospital which were not inspected this time.
- Staff had the training to keep people safe including training in how to recognise and respond to abuse. Staff assessed and managed the risk to patients including the risks presenting due to deterioration in patients' physical or mental health. Staff managed the risk of falls appropriately. Medicines were mostly managed safely, and the risk of infection was controlled and managed. Most services had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- The trust now provided effective care which achieved good outcomes, promoted a good quality of life, and was based on good practice. Managers ensured staff were competent and supported. Staff worked together as a team to benefit patients. Most key services were available seven days a week to support timely care. The trust had implemented new and regular audits and reviews to ensure care met fundamental standards.
- Staff were caring. We saw staff treating patients with compassion and kindness. Staff respected patients' privacy and dignity and took account of their individual needs. Staff supported and involved patients, families, and carers to understand their conditions.
- Services were planned to meet the needs of local people and took account of patients' individual needs. It was easy in most services for people to give feedback and raise concerns about care they received.
- Leaders had reviewed and improved governance systems and oversight of risk, issues and performance in frontline services. Fit and proper person checks were now in place for all directors.
- The trust had implemented systems to identify incidents involving restrictive interventions including restraint and rapid tranquilisation.
- The trust had also worked to improve culture in services and most staff told us they felt respected, supported, and valued. Staff and managers demonstrated consistent awareness of the improvements made to services and the areas requiring further improvement.

How we carried out the inspection

The inspections of the trust's core services and the focussed inspection of the trust's well-led key question was overseen by Sarah Dronsfield CQC Head of Hospitals Inspection and supported by two CQC inspection managers, eight CQC inspectors, a CQC assistant inspector, a CQC inspection planner and seven specialist professional advisors.

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

Our findings

Areas for improvement

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

Action the trust MUST take to improve:

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

Trust wide

- The trust must ensure systems operate effectively to identify, assess and manage risks in relation to care environments. **Regulation 12(1)(2)(b)(d) Safe care and treatment.**
- The trust must ensure staff undertake and record appropriate observations of service users' health after administering rapid tranquilisation. **Regulation 12(1)(2)(a)(b) Safe care and treatment.**
- The trust must ensure staff adhere to the requirement of the Mental Capacity Act. **Regulation 13(1)(2)(4)(b)(5) Safeguarding service users from abuse and improper treatment.**
- The trust must ensure incidents including serious incidents are identified, reported consistently, and categorised appropriately to reflect harm sustained by service users. **Regulation 17(1)(2)(a) Good governance.**
- The trust must ensure incidents including serious incidents are investigated within an appropriate timescale and improvements are made without delay. **Regulation 17(1)(2)(a) Good governance.**
- The trust must continue to improve, embed and sustain governance and risk management processes to assess, monitor and improve the quality of services. **Regulation 17(1)(2)(a)(b) Good governance.**
- The trust must ensure all staff required to physically restrain service users receive training which complies with the Restraint Reduction Network standards. **Regulation 18(1)(2)(a) Staffing.**

Urgent and emergency services (Northern General Hospital)

- The trust must have effective systems to ensure staff assess and manage the risks to service users in relation to their mental health. **Regulation 12(1)(2)(a)(b) Safe care and treatment.**
- The trust must have effective systems to identify, assess and manage and monitor risks to infection prevention control audits. **Regulation 12(1)(2)(a)(b) Safe care and treatment.**
- The trust must ensure staff undertake and appropriately record intentional rounding of all service users and ensure this is recorded, monitored, and audited with actions taken to improve compliance. **Regulation 12(1)(2)(a)(b) Safe care and treatment.**
- The trust must ensure staff receive the appropriate training in relation to the use of restrictive interventions including restraint and rapid tranquilisation. **Regulation 12(1)(2)(a)(b) Safe care and treatment.**
- The trust must implement an effective system to ensure all patients waiting to be admitted to the department from the ambulance queue are monitored for signs of deterioration. **Regulation 12(1)(2)(a)(b) Safe care and treatment.**

Our findings

- The trust must ensure that patients receive treatment within agreed timeframes and national targets. **Regulation 12(1)(2)(a)(b) Safe care and treatment.**
- The trust must ensure that ambulance handovers are completed within 15 minutes in line with guidance. **Regulation 12(1)(2)(a)(b) Safe care and treatment.**
- The trust must improve patient waiting times in the Accident and Emergency department. **Regulation 12(1)(2)(a)(b) Safe care and treatment.**
- The trust must ensure it implements effective systems to ensure staff adhere to trust policy in relation to the use of restrictive interventions including restraint and rapid tranquilisation. **Regulation 17(1)(2)(a)(b) Good governance.**
- The trust must have effective operational oversight of risk, issues and performance. **Regulation 17(1)(2)(a)(b) Good governance.**

Surgery (Royal Hallamshire Hospital)

- The trust must ensure that medicines must be supplied in sufficient quantities, managed safely and administered appropriately to make sure people are safe. **Regulation 12(2)(g) Safe care and treatment.**
- The trust must ensure that it is effectively assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. **Regulation 12(2)(h) Safe care and treatment.**
- The trust must ensure that the information to allow patients to make complaints is easily accessible. **Regulation 16(1) Receiving and acting on complaints.**
- The trust must continue to improve, embed and sustain governance and risk management processes to assess, monitor and improve the quality of services. **Regulation 17(1)(2)(a)(b) Good governance.**

Surgery (Northern General Hospital)

- The trust must ensure that medicines must be supplied in sufficient quantities, managed safely and administered appropriately to make sure people are safe. **Regulation 12(2)(g) Safe care and treatment.**
- The trust must ensure staff assess the risk of, and prevent, detect and control the spread of, infections, including those that are health care associated. **Regulation 12(2)(h) Safe care and treatment.**
- The trust must ensure that the information to allow patients to make complaints is easily accessible. **Regulation 16(1) Receiving and acting on complaints.**
- The trust must continue to improve, embed and sustain governance and risk management processes to assess, monitor and improve the quality of services. **Regulation 17(1)(2)(a)(b) Good governance.**

Medicine (Royal Hallamshire Hospital)

- The trust must ensure it implements effective systems to ensure staff adhere to trust policy in relation to the use of restrictive interventions including restraint and rapid tranquilisation. **Regulation 12(1)(2)(a)(f)(g) Safe care and treatment.**
- The trust must ensure staff receive the appropriate training in relation to the use of restrictive interventions including restraint and rapid tranquilisation. **Regulation 12(1)(2)(a)(f)(g) Safe care and treatment.**
- The trust must ensure that all patients have access to a call bell. **Regulation 12(1)(2)(a) Safe care and treatment.**

Our findings

- The service must ensure that staff complete mental capacity and best interest decisions, and they must clearly document the assessment and decision making-making process. **Regulation 13(1)(2)(4)(b)(5) Safeguarding service users from abuse and improper treatment.**
- The service must maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. **Regulation 17(1)(2)(a)(c) Good governance.**
- The service must ensure effective risk and governance systems are implemented to support safe, quality care. **Regulation 17(1)(2)(a) Good governance.**
- The trust must improve the monitoring of the effectiveness of care and treatment, timeliness of reviews and implementation of change. **Regulation 17(1)(2)(a) Good governance.**
- The trust must ensure that serious incidents are reported and investigated in a timely manner in line with national guidance. **Regulation 17(1)(2)(a) Good governance.**

Medicine (Northern General Hospital)

- The trust must ensure it implements effective systems to ensure staff adhere to trust policy in relation to the use of restrictive interventions including restraint and rapid tranquilisation. **Regulation 12(1)(2)(a)(f)(g) Safe care and treatment.**
- The trust must ensure staff receive the appropriate training in relation to the use of restrictive interventions including restraint and rapid tranquilisation. **Regulation 12(1)(2)(a)(f)(g) Safe care and treatment.**
- The trust must continue to implement effective systems to ensure staff consistently assess and manage risks in relation to service users who may be deteriorating. **Regulation 12(1)(2)(a) Safe care and treatment.**
- The service must ensure that staff complete mental capacity and best interest decisions, and they must clearly document the assessment and decision making-making process. **Regulation 13(1)(2)(4)(b)(5) Safeguarding service users from abuse and improper treatment.**
- The service must maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. **Regulation 17(1)(2)(a)(c) Good governance.**
- The service must ensure effective risk and governance systems are implemented to supports safe, hihg-quality quality care. **Regulation 17(1)(2)(a) Good governance.**
- The trust must improve the monitoring of the effectiveness of care and treatment, timeliness of reviews and implementation of change. **Regulation 17(1)(2)(a) Good governance.**
- The trust must ensure that serious incidents are reported and investigated in a timely manner in line with national guidance. **Regulation 17(1)(2)(a) Good governance.**

Maternity (Jessop Wing)

- The trust must ensure that delays to induction of labour continually reduce. **Regulation 12(2)(a) Safe care and treatment.**
- The trust must continue to improve and embed processes for investigating serious incidents. **12(2)(b) Safe care and treatment.**

Our findings

- The trust must continue to improve lessons learned and the sharing of lessons learned amongst the whole team and the wider service. **12(2)(b) Safe care and treatment.**
- The trust must ensure that training and performance appraisals are undertaken in line with national guidance. **Regulation 12(2)(b) Safe care and treatment.**
- The trust must ensure that staff follow systems and processes to prescribe and administer medicines safely. **Regulation 12(2)(b) Safe care and treatment.**
- The trust must improve infection control monitoring. **Regulation 12(2)(h) Safe care and treatment.**
- The trust must ensure that complaints are responded to within timelines outlined in their policy and procedure. **Regulation 16(1) Receiving and acting on complaints.**
- The trust must ensure effective risk and governance systems are implemented that supports safe, quality care. **Regulation 17(1)(2)(a) Good governance.**
- The trust must ensure that there is an up to date risk register in place which is monitored and regularly reviewed. **Regulation 17(1)(2)(a) Good governance.**
- The trust must improve the monitoring of the effectiveness of care and treatment, timeliness of reviews and implementation of change. **Regulation 17(1)(2)(a) Good governance.**
- The trust must ensure that serious incidents are reported and investigated in a timely manner in line with national guidance. **Regulation 17(1)(2)(a) Good governance.**
- The trust must ensure audit information is up to date, accurate and properly analysed and reviewed by people with the appropriate skills and competence to understand its significance. **Regulation 17(2)(c) Good governance.**

Action the trust SHOULD take to improve:

Urgent and emergency services (Northern General Hospital)

- The trust should implement systems to ensure all patients receive an initial mental health triage on arrival to the department.
- The trust should consider methods to improve staff appraisal rates.
- The trust should ensure that all patient records are stored securely.

Surgery (Royal Hallamshire Hospital)

- The trust should ensure that compliance with Mental Capacity Act and Deprivation of Liberty Safeguards training for clinical staff continues to improve.
- The trust should consider methods to improve staff appraisal rates.
- The trust should ensure it continues to reduce the number of cancelled elective procedures.
- The trust should consider methods to introduce a consistently applied audit schedule.
- The trust should consider expanding the existing audit schedule to include the assessment of pain.
- The trust should consider methods to be able to provide information at directorate and speciality levels.

Surgery (Northern General Hospital)

Our findings

- The trust should ensure that compliance with Mental Capacity Act and Deprivation of Liberty Safeguards training for clinical staff continues to improve.
- The trust should ensure that compliance with safeguarding training compliance continues to improve.
- The trust should consider methods to improve staff appraisal rates.
- The trust should ensure it continues to reduce the number of cancelled elective procedures.
- The trust should consider methods to improve compliance towards the cancer two week wait targets.
- The trust should consider expanding the audit programme to include the assessment of pain and the use of preoperative fasting.
- The trust should ensure that all patient records are stored securely.
- The trust should consider methods to be able to provide information at directorate and speciality levels.

Medicine (Northern General Hospital)

- The trust should ensure that information is widely displayed so that patients know how to complain.
- The trust should continue to implement effective systems to monitor incidents involving restrictive interventions including restraint and rapid tranquilisation.
- The trust should consider the implementation of a routine audit in relation to the administration and management of pain relief.
- The trust should ensure staff effectively manage the risks of infection by reviewing the use of fabric curtains and ensuring staff are bare below the elbows in clinical areas.

Maternity (Jessop Wing)

- The trust should implement electronic recording as per MBRRACE UK guidance.
- The trust should continue with the recruitment programme to ensure they maintain safe staffing levels.
- The trust should ensure epidural wait times are monitored and audited in line with national guidance.
- The trust should ensure policies are reviewed regularly to reflect best practice and national guidance.
- The trust should ensure that consultants requested for administering an epidural are available within 30 minutes of being required.
- The trust should ensure that agency staff receive a full induction and understand the service.

Is this organisation well-led?

Our rating of well-led stayed the same because we did not undertake a full review of the well-led key question. The well-led rating remains requires improvement although we found some improvements since our last inspection.

Leadership

The trust had implemented effective systems to ensure senior leaders had the necessary experience and ability to lead effectively and were individuals who were fit and proper to carry out the important role of director.

Our findings

Fit and proper persons requirement

The trust had improved systems to ensure compliance with the fit and proper persons regulation. Since our last inspection, the trust had reviewed and amended the fit and proper persons policy to include a requirement for all directors to undertake checks with the disclosure and barring service every three years.

We reviewed the personnel files for all executive directors and a sample of five records for non-executive directors including the trust chair. The files showed the trust had undertaken appropriate checks with the disclosure and barring service. The trust had ensured directors were able by reason of their health, after reasonable adjustments are made, of properly performing their roles by undertaking occupational health checks of all directors. The trust had undertaken and maintained records of checks with professional bodies where required for the role and had maintained records of checks with national registers.

Governance

The trust had improved governance processes to ensure patients received care which met their needs although there was more to do to sustain and embed improvements. The trust now had systems to ensure the board had appropriate oversight of frontline services. The trust had improved oversight of incidents although further work was needed to improve the time taken to report incidents.

The trust had implemented new systems to ensure incidents involving the use of restrictive interventions including physical restraint and rapid tranquilisation were identified and reported, The trust had addressed previous concerns and now had systems which showed the number and location of incidents involving restrictive interventions. The trust's data showed there were 118 restrictive interventions between 1 May 2022 and 1 September 2022. The most frequently used intervention was rapid tranquilisation.

The trust had improved systems to ensure incidents were categorised appropriately according to the level of harm patients sustained. We reviewed a sample of reports for incidents occurring during weeks randomly selected in July, August and September 2022. Our review found most incidents were correctly categorised according to the level of harm, with 1% of 945 incidents in our sample incorrectly categorised as 'no harm'.

The trust had not made significant improvement in the timeliness of incident reports since our last inspection. The Strategic Executive Information System (STEIS) is a national system used by all healthcare providers who provide NHS funded care to report serious incidents. The trust reported 85 serious incidents to STEIS between 1 March 2022 and 30 September 2022. The trust took more than 30 days to identify and report more than 25% of these incidents as serious incidents and 15% of serious incidents were not identified and reported for more than 90 days. The National Learning and Reporting System (NRLS) is a central database for patient safety incidents. The trust reported 17915 incidents to NRLS between 1 March 2022 and 30 September 2022. The trust took more than 30 days to identify and report more than 30% of these incidents and 11% of incidents were not reported for more than 90 days.

The trust still had a significant backlog of serious incidents requiring investigation. In maternity services the trust had incidents which were still under investigation including some incidents which had occurred in 2021.

Our findings

Management of risk, issues and performance

The trust had improved systems for identifying, escalating and managing risks, issues and performance. The trust had implemented new approaches to maintain operational oversight at all levels and manage and reduce risks to patients. However, there were some areas where the trust's pace of change had resulted in risks which had not been addressed by the time of our inspection.

The trust had improved systems to ensure there was operational focus, oversight and action to mitigate the risk to patients receiving care in frontline services. Our inspection found significant improvement in the how staff assessed and managed the risk to patients including the risks presenting due to deterioration in patients' physical or mental health. Staff now managed the risk of falls appropriately. Medicines were mostly managed safely, and the risk of infection was controlled and managed. Compliance with mandatory training had improved across all services and most services now had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Most risks to services were identified and there were plans in place to make further improvements. Unlike previous inspections, the improvements made by the trust found during this inspection meant that we did not find concerns requiring CQC to take significant enforcement action against the trust.

The trust responded appropriately to our previous inspection report and enforcement action and took action to make improvements by developing and implementing an action plan. The action plan grouped together the concerns identified by our previous inspection into 17 'outcomes'. Each outcome corresponded to an overarching aim to address identified concerns and ensure services were safe, effective, responsive and well-led.

The trust had introduced a programme of quality support visits to wards. These were structured assessments of compliance with the outcomes identified in the improvement action plan which related to frontline care. The trust had focussed initially on 12 priority wards identified as requiring more intensive support. By the time we inspected the trust had undertaken quality support visits on 60-70 wards looking at specific outcomes. A report presented to the Trust's Executive Group in September 2022 showed that progress had been made against most outcomes. The report highlighted ongoing areas of concerns and provided details of further actions planned to make improvement. Areas of concern included use of physical restraint, adherence to the Mental Capacity Act, secure storage of patient records, and appropriate use of personal protective equipment. These were areas of concern found during our inspection and showed the visits had produced a realistic assessment of improvement in line with the trust's action plan.

The trust had implemented new systems to ensure the board had oversight of risk in frontline services. Since our last inspection, the trust had reviewed and amended the Integrated Risk and Assurance Report (IRAR). The trust had introduced a new a framework for risk management which was approved in June 2022. The trust had started to introduce a clear separation between systems to monitor risks to the trust's ability to deliver on its strategy which were captured in a Board Assurance Framework (BAF) and extreme operational risks captured in a corporate risk register (CRR).

The Board Assurance Framework was presented in draft to the board in July 2022 and the first full version was considered by the board in September 2022. The board had agreed eight strategic risks, and each had a strategic risk owner. The trust had improved internal systems to ensure there was realistic assessment and ratings of assurance. The Board Assurance Framework presented in September 2022 noted there were four strategic risks which had a 'limited' aggregated assurance rating and a risk likelihood rating of 'likely'.

Operational risks identified in frontline services with a risk score of 15 or more were defined as an extreme risk and were included on the trust's new Corporate Risk Register report which was presented to the trust's board. Extreme risks were assessed and aligned to one or more of the trust's strategic risks as identified in the Board Assurance Framework. The

Our findings

report presented to the board in September 2022 showed there were 35 extreme risks and five risks were overdue for review. The report did not include details of the controls or ongoing mitigating actions for each risk. The report noted four risks had been closed including an identified risk in relation to the improper use of rapid tranquilisation which would not meet trust policy and national guidance. Our inspection found this was still an area of concern and a risk requiring further action by the trust.

There were some areas where the trust's pace of change had resulted in risks which had not been addressed by the time of our inspection. Staff did not complete and record the observations of patients' physical health after the administration of rapid tranquilisation. The trust had not trained sufficient numbers of staff to ensure physical restraint was undertaken safely and appropriately. The trust continued to rely on untrained staff to restrain patients when needed. Incident reports continued to show staff without the required training were required to restrain patients.

Maternity services

Our previous inspections of the trust's maternity services in March 2021, October 2021 and November 2021 identified significant concerns requiring CQC to use our powers to take enforcement action against the trust. Although there was more to do to sustain and embed improvements, we found the trust had made significant improvements in the oversight and management of risk, issues and performance in maternity services.

Key to tables					
Ratings	**Not rated**	**Inadequate**	**Requires improvement**	**Good**	**Outstanding**
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔🡐	🡅	🡅🡅	🡇	🡇🡇
Month Year = Date last rating published					

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement 🡅 Dec 2022	Good 🡅 Dec 2022	Good 🡅 Dec 2022	Requires Improvement ➔🡐 Dec 2022	Requires Improvement ➔🡐 Dec 2022	Requires Improvement ➔🡐 Dec 2022

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

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
The Charles Clifford Dental Hospital	Good Jun 2016	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Good Jun 2016	Good Jun 2016
Royal Hallamshire Hospital	Requires Improvement ↑ Dec 2022	Good ↑ Dec 2022	Good ↑ Dec 2022	Requires Improvement →← Dec 2022	Requires Improvement →← Dec 2022	Requires Improvement →← Dec 2022
Jessop Wing	Requires Improvement ↑ Dec 2022	Requires Improvement →← Dec 2022	Good ↑ Dec 2022	Requires Improvement ↑ Dec 2022	Requires Improvement ↑ Dec 2022	Requires Improvement ↑ Dec 2022
Northern General Hospital	Requires Improvement ↑ Dec 2022	Good ↑ Dec 2022	Good ↑ Dec 2022	Requires Improvement →← Dec 2022	Requires Improvement →← Dec 2022	Requires Improvement →← Dec 2022
Weston Park Hospital	Good Nov 2018	Requires improvement Nov 2018	Outstanding Nov 2018	Outstanding Nov 2018	Requires improvement Nov 2018	Requires improvement Nov 2018
Sheffield Dialysis Unit	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Overall trust	Requires Improvement ↑ Dec 2022	Good ↑ Dec 2022	Good ↑ Dec 2022	Requires Improvement →← Dec 2022	Requires Improvement →← Dec 2022	Requires Improvement →← Dec 2022

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

Rating for The Charles Clifford Dental Hospital

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

Rating for Royal Hallamshire Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ↑ Dec 2022	Requires Improvement ↑ Dec 2022	Good ↑↑ Dec 2022	Requires Improvement ↑ Dec 2022	Requires Improvement ↑ Dec 2022	Requires Improvement ↑ Dec 2022
Services for children & young people	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Critical care	Good Jun 2016	Outstanding Jun 2016	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
End of life care	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018
Maternity and gynaecology	Good Jun 2016	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
Outpatients and diagnostic imaging	Good Jun 2016	Not rated	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
Surgery	Requires Improvement ↑ Dec 2022	Good ↑ Dec 2022	Good ↑ Dec 2022	Requires Improvement →← Dec 2022	Requires Improvement →← Dec 2022	Requires Improvement →← Dec 2022
Urgent and emergency services	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018
Overall	Requires Improvement ↑ Dec 2022	Good ↑ Dec 2022	Good ↑ Dec 2022	Requires Improvement →← Dec 2022	Requires Improvement →← Dec 2022	Requires Improvement →← Dec 2022

Rating for Jessop Wing

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	Requires Improvement ↑ Dec 2022	Requires Improvement →← Dec 2022	Good ↑ Dec 2022	Requires Improvement ↑ Dec 2022	Requires Improvement ↑ Dec 2022	Requires Improvement ↑ Dec 2022
Overall	Requires Improvement ↑ Dec 2022	Requires Improvement →← Dec 2022	Good ↑ Dec 2022	Requires Improvement ↑ Dec 2022	Requires Improvement ↑ Dec 2022	Requires Improvement ↑ Dec 2022

Rating for Northern General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ➔🡐 Dec 2022	Requires Improvement ➔🡐 Dec 2022	Good ➔🡐 Dec 2022	Requires Improvement ➔🡐 Dec 2022	Requires Improvement ➔🡐 Dec 2022	Requires Improvement ➔🡐 Dec 2022
Critical care	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Good Jun 2016	Outstanding Jun 2016
End of life care	Good Nov 2018	Good Nov 2018	Good Nov 2018	Outstanding Nov 2018	Good Nov 2018	Good Nov 2018
Outpatients and diagnostic imaging	Good Jun 2016	Not rated	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
Surgery	Requires Improvement 🡅 Dec 2022	Good 🡅 Dec 2022	Good 🡅 Dec 2022	Requires Improvement ➔🡐 Dec 2022	Requires Improvement ➔🡐 Dec 2022	Requires Improvement ➔🡐 Dec 2022
Urgent and emergency services	Requires Improvement 🡅 Dec 2022	Requires Improvement ➔🡐 Dec 2022	Good 🡅 Dec 2022	Requires Improvement ➔🡐 Dec 2022	Requires Improvement 🡅 Dec 2022	Requires Improvement 🡅 Dec 2022
Overall	Requires Improvement 🡅 Dec 2022	Good 🡅 Dec 2022	Good 🡅 Dec 2022	Requires Improvement ➔🡐 Dec 2022	Requires Improvement ➔🡐 Dec 2022	Requires Improvement ➔🡐 Dec 2022

Rating for Weston Park Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018	Requires improvement Nov 2018	Good Nov 2018
End of life care	Good Nov 2018	Requires improvement Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018
Outpatients and diagnostic imaging	Good Jun 2016	Not rated	Outstanding Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
Overall	Good Nov 2018	Requires improvement Nov 2018	Outstanding Nov 2018	Outstanding Nov 2018	Requires improvement Nov 2018	Requires improvement Nov 2018

Rating for Sheffield Dialysis Unit

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Overall	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community dental services	Good Jun 2016	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
Community health services for adults	Good Jun 2016	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
Community end of life care	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018	Good Nov 2018
Community health inpatient services	Requires improvement Apr 2022	Requires improvement Apr 2022	Requires improvement Apr 2022	Good Apr 2022	Requires improvement Apr 2022	Requires improvement Apr 2022

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

Care Quality Commission

Royal Hallamshire Hospital

Glossop Road
Sheffield
S10 2JF
Tel: 01142711900
www.sth.nhs.uk

Description of this hospital

The Royal Hallamshire Hospital is one of sixteen locations where Sheffield Teaching Hospitals NHS Foundation Trust provides care.

During this inspection we inspected and rated the following core services at this location:

- Medical care (including older people's care)
- Surgery

Medical care (including older people's care)

Requires Improvement ↑

Is the service safe?

Requires Improvement ↑

Our rating of safe improved. We rated it as requires improvement.

Mandatory Training

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

Nursing and Medical staff received and kept up-to-date with their mandatory training. All specialities within the medicine division had exceeded the trust's target of 90% compliance.

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

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. All clinical staff told us that they were given opportunities to complete mandatory training and were able to claim back any time used outside of work.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers were alerted if staff were approaching expiry of existing training, we saw managers using a red, amber, green (RAG) system to maintain oversight of staff's training records.

Safeguarding

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

Nursing and medical staff received training specific for their role on how to recognise and report abuse. The trust had up to date safeguarding policies for adults and children. Staff had access to safeguarding advice and support from link nurses on the ward, from the trust's intranet, ward managers and the trust's central safeguarding team. We reviewed the trust's training statistics in relation to safeguarding, which demonstrated that staff were above the trust target of 90% for both Level 1 and Level 2 modules.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Safeguarding was a standard agenda item we observed being discussed at handovers and safety huddles.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we spoke could describe how to complete a safeguarding referral. They were also aware of who the safeguarding lead was and how to contact them. Staff told us they would always escalate safeguarding concerns to the ward manager.

Medical care (including older people's care)

Staff demonstrated awareness and understanding of safeguarding Staff knew how to make a safeguarding referral and who to inform if they had concerns. The trust had a lead for safeguarding and they (or their delegate) represented the trust at the local safeguarding boards for adults and children. Trust wide level monitoring took place through the safeguarding team who reported at least annually to the board of directors.

Children were not currently permitted to visit on the wards except in exceptional circumstances, but staff could articulate safe procedures if children were visiting the ward.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained. We observed throughout the service that there were fabric curtains placed in situ in clinical areas. There was no evidence of when these had been installed or due for replacement. This was not in line with best practice, due to the permeable nature of the fabric.

The service generally performed well for cleanliness. In line with national guidance from NHSE/I Estates PLACE was suspended for the last two years due to the COVID-19 pandemic, and therefore no results for 2020/21 were available. The trust had plans to recommence with PLACE submissions later in the year. We did see local ward cleanliness audits that had been completed and all wards were consistently above the trust target of 95%.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). There were adequate supplies of hand gel and PPE in all areas, however not all staff were compliant with the bare-below-elbow requirement. We observed staff wearing long sleeved shirts and watches whilst in clinical areas. In addition, we observed fabric curtains in place throughout the service. There was no information available as to when these had been installed, or when they were due to be replaced. Due to their permeable nature, these posed a risk to patients in relation to infection control.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw a number of examples where domestic staff and nursing staff had cleaned equipment and clinical areas. Cleaning staff were able to articulate the differing cleaning solutions used in line with guidance.

There were designated isolation side rooms for patients with COVID-19 symptoms or who were known to be COVID-19 positive. Staff knew which side rooms were designated for these patients and were able to describe how they would provide care to patients with symptoms or newly diagnosed with COVID-19 in accordance with trust policy.

Wards we visited reported low or no cases of clostridium difficile (C. diff) and methicillin resistant staphylococcus aureus (MRSA). Staff described how they worked with the trust's infection prevention control team on a programme of quality improvement at ward level. We reviewed the trusts hand hygiene audit results for the previous 12 months which demonstrated good compliance rates on individual wards for hand hygiene compliance.

Environment and equipment

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

Patients could not always reach call bells and staff responded quickly when called. On ward L1 we observed on one ward that not all patients had access to call bells, as these had been damaged and were awaiting replacements. Whilst

staff had been allocated to remain within patient bays, it was unclear as to how patients would attract the attention of staff should they be required to leave the bay. Patients raised concerns with us regarding feeling uneasy at not being able to readily call for assistance if required. However, on all other wards during our inspection, where patients had access to their bells we saw that staff responded quickly when patients requested assistance.

The design of the environment followed national guidance.

Staff carried out daily safety checks of specialist equipment. All equipment was subject to routine planned preventative maintenance as defined by the equipment manufacturer and we saw that equipment had been maintained and safety checked. The trust had systems in place for recording the service and maintenance of equipment, identified through compliance stickers. Managers assured us repairs were made promptly if a piece of equipment developed a fault. Medical devices we looked at were mostly labelled to indicate when they were last serviced or checked for electrical safety, and to identify next test dates.

Sharps bins were properly assembled, stored off the floor, not over full and signed and dated. Oxygen cylinders were stored in line with national guidance. Fire exits were clear and unobstructed. The resuscitation trolleys were situated on each ward and were all stocked correctly. We reviewed all check lists completed by staff and saw no omissions or errors.

The service had suitable facilities to meet the needs of patients' families. Wards we visited had boards to display public information about the staff on the ward, visiting times, who was in charge, and other useful information, such as mandatory training compliance. There were additional areas such as day rooms and/or activity rooms that could be accessed by patients and families during their admission, however we did not observe these areas in use during our inspection.

Staff on most wards told us that they had enough equipment to support them to safely care for patients, for example for use when moving and handling or caring for bariatric patients. This included pressure-relieving aids. Staff in endoscopy received training for specialist equipment from the manufacturers who came into the hospital when necessary. The endoscopy unit had Joint Advisory Group (JAG) accreditation. JAG accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the criteria set out in the JAG standards.

Staff disposed of clinical waste safely. We saw all clinical waste sharps bins were used and stored in accordance with national guidance.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients (NEWS2). This helped staff to identify and escalate deterioration in a patient's condition. The NEWS2 alert system was embedded into practice with individual electronic ward boards providing oversight of the clinical area. A trust wide audit had been completed in relation to the escalation of Deteriorating Patients, The period of time reviewed was between the 4th -10th April 22. Data collection took place May 23rd – June 23rd. Results showed 53 patients were identified as having a NEWS2 score of 7+ during the time period audited, and 37 sets of notes were identified and included in the analysis. Only 30% (11/37) of observations had been completed at the correct frequency. Overall, only two sets of notes had a 'Deteriorating Patient Sheet' filed and neither were fully completed. The audit identified further areas of concern, specifically that there was a lack of documented evidence that:

Medical care (including older people's care)

- Observations are measured at the correct frequency based upon NEWS2 score
- Use of the Deteriorating Patient Sheet
- All patients are reviewed by a medic following escalation
- All patients are reviewed within timescales
- All patients not reviewed within timescales are escalated to the Duty Matron

The trust implemented the following ongoing actions to address the concerns identified as a result of the trust wide audit;

- Introduction of the deteriorating patient bleep holder on all inpatient wards (June 22)
- Introduction of the e-whiteboard alert for escalation of patient deterioration (June 22)
- Audit compliance with deteriorating patient bleep holder on all inpatient wards (Jul-Sept 22)
- Audit use of the e-whiteboard alert for escalation of patient deterioration (Jul-Sept 22)
- Identify areas for further training (Jul-Sept 22)

During our inspection, we observed that the trust had made progress in the implementation of these actions. In all of the records reviewed NEWS charts we reviewed were completed correctly, and there was clear evidence of escalation with deteriorating patients.

Staff knew about and dealt with any specific risk issues. We noted improvements to patient risk assessments, which were now completed on admission where appropriate and now included information relating to falls, nutrition and hydration, pressure area care, dementia and moving and handling. We saw evidence that these risk assessments were used to plan individualised care for each patient and relevant pathways were initiated when required. There was evidence that risk mitigations had taken place post-assessment. For example, the service had cohorted bays with a staff member present the full time to respond to patient needs.

The service had a policy and protocol in place to ensure that patients were regularly screened for sepsis. Sepsis training for staff is embedded within the job specific essential training, which covers modules such as patient deterioration, escalation, sepsis and acute kidney injury. We reviewed the trusts training compliance figures for sepsis training which evidenced training compliance within the division of 89% and 96% for medical and nursing staff retrospectively against a target rate of 90%.

The trust incorporated sepsis screening as part of their Escalation of Deteriorating Patients Audit, in line with the National Institute for Health and Care Excellence (NICE). The audit focused on reviewing all deteriorating patients and did not include specific areas reviewing compliance against sepsis policies or protocols.

Guidance for sepsis stipulates that patients presenting with one or more high risk criteria should receive antibiotics within an hour of it being identified. The Escalation of Deteriorating Patients audit did not include details as to how the trust were assured they had administered antibiotics in line with national guidance.

The trust provided copies of the sepsis workplan for 2022/23, which outlined plans to develop their 1sepsis dashboards to give wards data which would help them measure their response to deteriorating patients, enabling them to test

change ideas in their areas, and continuously improve responses to Sepsis. There were no associated timescales attached to this workplan to outline when the changes to the dashboard would be implemented, and the trust did not provide any examples of compliance data generated through this dashboard. We were not assured as to how the trust maintained oversight of the treatment of patients with identified sepsis.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. Staff could make referral requests on the IT platform or paper and also had the option to request over the telephone. Staff told us that the links with the mental health team were very good and that they could rely on a prompt response if they were worried about a patient.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. We observed staff undertaking daily mental health risk assessments for patients where required.

We observed across all wards inspected that violence and aggression from patients had been listed as one of the top three risks. Staff told us that whilst they were able to use their training in de-escalation, there were instances where restrictive interventions such as restraint and rapid tranquilisation were used. We reviewed two sets of patient notes where rapid tranquilisation had been administered and observed that there had been no recording of patients' physical health observations post administration. This was not in line with the trusts policy for rapid tranquilisation which states that "Patient is reassessed at regular intervals or when their health needs change in accordance with local policy. The patient's vital signs should be diligently monitored in accordance with the Trust Guidelines on Rapid Tranquilisation." This had been raised with the trust as an area of concerns in previous inspections, and we were not assured that the trust had taken sufficient action to ensure that the administration of rapid tranquilisation was completed in a safe manner.

We reviewed instances of the use of restrictive interventions from the 1st May to the 1st of September 2022 which showed there were 118 restrictive practice incidents logged on Datix trustwide.

The service relied on security staff to assist in high-risk incidents where patients were highly aggressive or displayed violent behaviour. Staff did not have or were not aware of guidance for when to call for security staff to assist in managing an incident and security staff did not have clear guidance for how to prioritise responses to staff requests for assistance.

Security staff were required to provide one to one observations of patients presenting with high risks of violence, aggression or absconding. In incidents reports we saw security staff were required to restrain patients. However, security staff had not had the training required to manage restraint safely in a healthcare setting. The training provided to security staff did not meet the standards of the Restraint Reduction Network. This had been raised with the trust as part of the previous inspection, and we were not assured that the trust had taken sufficient action to address these concerns. These concerns had been entered onto the trust's risk register, we noted that these had been listed as actioned and closed.

Staff shared key information to keep patients safe when handing over their care to others.Shift changes and handovers included all necessary key information to keep patients safe. We reviewed the hand over sheets on all wards we inspected. We observed that key risks were discussed, and information disseminated to reduce risks. We observed handovers across all wards and observed that all used Situation, Background, Assessment and Recommendation (SBAR). Staff told us that individual wards instigated safety huddles as part of the daily handover process where patient

risks were discussed including: staffing, number of patients, risk of falls, enhanced care patients, high NEWS, end of life, cannula care, pressure ulcers, infections, infection control and COVID 19 swab status and do not attempt cardiopulmonary resuscitation orders. For medical outliers, staff could track medical outliers using the trust's electronic patient record system. Staff told us outliers were seen daily by a doctor for the speciality concerned.

Staffing

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

The trust had a Nursing and Midwifery Staffing Escalation Policy, which clearly outlined processes for addressing any shortfalls in staffing and how this should be escalated via senior nurses and midwives on duty or via relevant on-call teams is clearly defined. In addition, the trust had agreed metrics that would identify wards requiring potential further support and/or review – this included if wards had Care Hours per Patient Day (CHPPD) below 85%. A trigger in either one or a combination of these criteria identified in one month would require a Nurse Director (ND) to undertake a professional judgment review within the clinical area and ensure any identified issues are actioned locally, as part of the "How Healthy is Your Ward" process.

Nurse staffing

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

Most wards had enough nursing and support staff to keep patients safe. We reviewed the Monthly Nurse and Midwifery Staffing Report for the month of August 2022. Within this, there were 4 wards reported a deficit between planned and actual Registered Nurse (RN)/Registered Midwife (RM) Care Hours per Patient Day (CHPPD) below 85%. Wards triggering a greater than 15% deficit between planned and actual RN CHPPD were H1 RHH (Q1), Frailty Unit – Huntsman 1, G2 (H2), Ward Q2 It was noted that these 4 wards were a part of the Integrated Geriatric and Stroke Medicine Department, with three being based at the Royal Hallamshire Hospital Site.

We reviewed incident reports that were in relation to staffing concerns that had been captured via the trusts incident reporting system. For the month of August 2022, there had been 29 incidents raised, with four relating to an area that has triggered for RN CHPPD; H1 (3 incidents) and G2 (1 incidents) all of these incidents were rated as No/Low harm all had appropriate escalation action reported.

We found planned and actual staffing levels were displayed on the entrance to all medical wards we visited. To try and ensure staffing remained safe, both during the day and night, staff used professional judgment, together with an electronic rostering system. A matron of the day was available for any escalation and followed a clear policy of escalation for any unplanned deviations in staffing levels. We were told that following the previous inspection there had been a significant recruitment of overseas nursing staff which had a positive impact.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Senior leaders told us they used the electronic rostering system when redeploying clinical staff to other wards to assess skill and competency. Discussions with ward managers/matrons/bleep holders and risk assessments are completed, based on ward requirements and the staff competency and skill set. Leaders looked across the whole division and moved staff across site when needed based on skills available. The ward manager could adjust staffing levels daily according to the needs of patients.

Medical care (including older people's care)

The number of nurses and healthcare assistants matched the planned numbers. An electronic staffing software was used to support the deployment of staff on a daily basis to keep wards safe and mitigate or reduce risks. The system was able to take into account acuity and dependency of patients and available staff. The electronic system is a daily staffing software matching nursing staffing levels to patient acuity, in real time, allowing informed decision making on staffing levels across the hospital. It enabled visibility and tracking of staff attendance, recording of red flags and professional judgement. Staffing shortfalls were reported and escalated through the central nursing team and could also be reported using the electronic system.

Divisional morning 'huddles' were chaired by the matron of the day. Huddles were attended by the ward shift leads to highlight concerns they may have had in relation to dependency, acuity and staffing levels. This enabled an early response and support to be planned by the divisional senior nursing team. Matrons ensured acuity and dependency levels had been updated on the system and added mitigation, their professional judgement, and changed the risk/colour appropriately to reflect the staffing risk level following the actions taken. Electronic staffing data was reviewed at the trust wide safe staffing meeting where deployment of staff and mutual aid across divisions was agreed.

The service had low vacancy and turnover rates.

In addition, the service had reducing sickness rates. At the time of the inspection, the medical division had a reported total sickness rate of 3.73% for the 6 month period from March to August 2022.

The service had low rates of bank and agency nurses used on the wards.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers told us that permanent ward staff usually took any available additional shifts which was preferred as it maintained continuity of care for the patients.

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

Medical staffing

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

The service had enough medical staff to keep patients safe. Consultants carried out board rounds every day, which included a discussion of each patient with junior doctors. Patients' own specialty doctor would review them twice a week.

The medical staff matched the planned number. All the services we visited had a daily consultant attended board round and multi-disciplinary team meetings (MDTs). All specialities we visited had medicine consultant cover at least two days a week with on call 24hour for weekends and out of hours. Staff outlined established processed to cover short notice gaps (e.g. sickness) to ensure suitable medical cover was established in a timely manner.

The service always had a consultant on call during evenings and weekends. At weekends, there was an on-call rota, and access to consultants present onsite, though not present on every ward. The Trust had an action card outlining the process to follow. Out of hours gaps had been identified as an area of high risk therefore additional doctors had been rostered overnight to mitigate the impact of uncovered out of hours gaps.

Medical care (including older people's care)

The service had low vacancy, sickness and turnover rates for medical staff.

The service had reducing rates of bank and locum staff. In the instance of any identified short-term gaps – the trust had an established process of identified in the first instance an internal locum, and if this was not successful the trust would seek to appoint an agency locum.

Managers could access locums when they needed additional medical staff, and they had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. To support the medicine wards there were a range of junior doctors who reported good supervision, good learning, and good support from nursing staff. The trust also made use of physician associate roles.

Records

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

Staff used an electronic patient record supported by supplementary nursing paper records for each patient. Patient notes were comprehensive, and all staff could access them easily. We reviewed 32 full sets of patient notes and sections of patients records when looking at examples of care we had observed across the medical wards inspected. In the records we looked at we found that allergies were recorded, medications were reconciled, and assessments, whether for fluids or food, weight, early warning scores, or falls or pressure ulcer care plans, were completed where necessary. We saw that mental health assessments, mental capacity assessments and deprivation of liberty safeguards applications were completed in full where necessary.

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

Records were not always stored securely. At our last inspection we said the trust must ensure confidential records are stored securely in line with national guidance. At this inspection on wards we visited notes trollies were mostly left unlocked and unattended with patient notes stored underneath trollies, easily accessible to visitors. This was in breach of trust policy and General Data Protection Regulation (GDPR). Individual patient paper records were stored in folders outside of each bay, or in folders not stored securely in the bay

We noted that version-controlled documents were reviewed in line with trust policy and national guidance. Electronic whiteboards were used on all wards we visited, these recorded key information about patient risks and treatment including flags for patients living with dementia, learning disabilities, patient acuity and discharge plans. The boards ensured that staff had easy access to key information, such as reviews by other members of the multi-disciplinary team and clinical observations.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Electronic prescriptions reviewed on inspection all had allergy status records completed. We found oxygen being prescribed appropriately, where it was being administered to patients. we checked the storage of medicines, fluids and gases on the wards we visited. We found that medicines, fluids and gases were stored securely in appropriately locked rooms or fridges. Checks were in

place and stocks seen were in date. We found controlled drugs were locked away in a metal cupboard in a locked room. We carried out a random check of controlled drugs and found all records of controlled drugs that staff kept were complete with no gaps. Stock seen was in date.

We reviewed the use of rapid tranquilisation medicines and found this was not subject to any overarching medicine audit. On records we reviewed, where rapid tranquilisation medication was used, we found staff were not recording use in accordance with trust policy. For example, after administration, staff were not recording patient observations hourly. We raised this with staff at the time of our inspection.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Wards we visited did benefit from a visit by a pharmacy technician each day and during core hours take home medications were being clinically checked and dispensed and patient medication reconciled. We found that staff benefited from 24-hour pharmacy availability.

Staff completed medicines records accurately and kept them up-to-date. Electronic prescriptions reviewed on inspection all had administration records completed.

Staff stored and managed all medicines and prescribing documents safely. Medicines requiring specific secure storage were managed appropriately and records of their administration maintained. Emergency medicines were stored on resuscitation trolleys in accessible areas with regular checks on content and expiry dates an all wards inspected.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services. Pharmacy technicians and pharmacists told us they provided the medicine reconciliation service for patients. Pharmacist additionally, completing targeted reconciliation of specific patients. Errors relating to medicines reconciliation were reported via the trust incident system and investigated and followed up with the pharmacy staff involved.

Staff learned from safety alerts and incidents to improve practice. Safety alerts would be discussed during safety huddles to ensure all staff were aware of them. We were also told that safety alerts were sent by email to all staff.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Incidents

The service managed patient safety incidents. Staff recognised and reported incidents and near misses but did not always do this in a timely manner. Managers investigated incidents and shared lessons learned with the whole team and the wider service once complete. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff were aware of the importance of incident reporting and how to report an incident using the electronic reporting system. Staff we spoke with told us they felt incidents were dealt with appropriately and that learning was taken from them.

Staff raised concerns and reported incidents and near misses in line with trust policy. Ward leaders could give some examples of recent incidents that had resulted in shared learning for the ward. Feedback and learning from incidents were cascaded to staff both individually and via team meetings. Staff could request to receive feedback via an email linked to the electronic reporting system.

Medical care (including older people's care)

The service had no never events on any wards.

Staff did not always report serious incidents clearly and in line with trust policy. We reviewed NRLS between October 2021 and August 2022 and found that incident report times were variable and not always timely. Out of 24990, incidents there were 917 reported 90+ days after the incident occurred. 196 of these had been graded as moderate and above. This means that investigations and lessons learned were untimely.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Ward managers and most of the staff we spoke to knew of the Duty of Candour requirements. They understood that this involved being open and honest with patients and had been involved in investigations and responding to patients and families

Staff received feedback from investigation of incidents, both internal and external to the service although this was not always timely. Incident learning was shared on individual ward boards for openness and transparency. Staff told us that they would receive initial feedback from reporting an incident and further feedback would be provided once the incident had been investigated.

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

There was evidence that changes had been made as a result of feedback.

Managers investigated incidents thoroughly, but investigations were not always completed in a timely manner due to delays in reporting. Patients and their families were involved in these investigations. We reviewed five incident reports supplied by the trust, each of which demonstrated that Duty of Candour had been applied, where relevant families had been involved throughout the investigation process, evidence of a corresponding acting plan and identified learning to be applied as a result of the investigation.

Managers debriefed and supported staff after any serious incidents.

Is the service effective?

Requires Improvement ↑

Our rating of effective improved. We rated it as requires improvement.

Evidence-based care and treatment

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

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

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. The trust had systems and processes in place to ensure that care was given by the service according to published national guidance such as that issued by National Institute for Health and Care Excellence (NICE). All staff we spoke with could access, via

the trust's intranet, guidelines, policies, and procedures relevant to their role.

Clinical policies had been developed based on national guidance such as the National Institute for Health and Care Excellence (NICE). We found care was provided based on best possible evidence and in line with national guidance.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Teams had access to a psychiatric liaison team on site. Staff undertook a daily assessment of patients mental health. We saw that this was a standard agenda item in the newly introduced safety huddles.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. We observed prior to mealtimes, staff undertook a huddle to discuss patients with any specific dietary requirements and identify patients who may require assistance with their meals. We saw snack and drinks trolleys on wards that were accessible to patients. All patients had individual access to their own water jugs and cups within their bays or side room.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. We reviewed 32 sets of patient care records and saw no omissions or errors in the completion of diet and fluid records.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it and patients requiring this were frequently reviewed. Where modified diets or fluid were required, assessments of a patient's requirements were detailed above their beds. There were issues around patients receiving specialist support from speech and language therapists over the weekend, but staff were able to describe the mitigation in place.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. All staff we spoke with knew about pain assessments and how to score patients level of pain. We saw in all patient records that we reviewed that pain scores were accurately recorded.

Patients received pain relief soon after requesting it. Patients we spoke with told us staff managed their pain in a timely way.

Staff prescribed, administered and recorded pain relief accurately. Pain relief was prescribed, and staff would request additional pain relief from medical staff, if required

We requested any completed pain audits, but none were provided.

Medical care (including older people's care)

Patient outcomes

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

The service participated in relevant national clinical audits. Managers and staff used the results to monitor and improve care and treatment. We saw audit information displayed in ward areas and ward managers discussed results with staff.

Outcomes for patients were not always positive, consistent and did not always meet expectations, such as national standards.The trust provided a range of supporting action plans following their clinical audit programme, which identified areas in which the trust was not in line with national standards. Action plans were also provided which contained high level summaries on how the trust would develop their services to better meet the needs of patients.

We reviewed the trusts Sentinel Stroke National Audit Programme (SSNAP) 2020/2021 and the corresponding action plan, in which the trust had been graded as band A. Trust performance in relation to thrombolysis was not in line with national standards of 20 % of all patients receiving treatment and less than 40 minutes median time between clock start and thrombolysis. Audit results highlighted that only 9.7% of patients are given thrombolysis, and there was a 54-minute median time between clock start and thrombolysis. Whilst this was an improvement on the 2019/20 position and the trust had not been identified as an outlier, we were not assured the trust was moving at pace to improve their position.

We reviewed the trusts National Lung Cancer Audit (NLCA) 2018 data (published 2020) and 2019-2020 data (published 2022), and the associated action plans. In the 2020 Report (2018 data) the trust results had continued to remain below the national average for two key performance indicators;

1. Pathological diagnosis (%) – Trust performance was 63.8% against the 69.4% national average. This resulted in 36.2% of patients not receiving a pathological diagnosis.
2. Anticancer treatment (%) – Trust performance was 54.3% against the 58.5% national average. This resulted in 45.7% of patients not receiving anticancer treatment

In the 2022 Report (2019 and 2020 data) it wasn't possible to produce trust level data, and therefore national and alliance-level data was published. This meant that the trust were unable to risk assess the 2019 and 2020 results for the NLCA audit.

We reviewed the trusts National COPD Secondary Care Audit September 2019 - February 2020 and the associated action plan. The trust had made significant improvements compared to the 2018/19 results that had indicated 33% of patients who required oxygen had not had this prescribed. The 2019/20 data highlighted that 100% of patients who required oxygen had this prescribed. However, the trust had failed to take action to address non-compliance against the following key performance indicators;

- 66% of patients requiring non intensive ventilation did not receive it within 2 hours of arrival.
- A spirometry result is not available for a patient admitted to hospital with an acute exacerbation of COPD. A spirometry result was not available for 35% of patients.
- 70% of smokers were not referred to behavioural change intervention and/or prescribed a stop smoking drug, however 100% of smokers were offered this intervention.
- A patient does not receive a respiratory review within 24 hours of admission. 6% of patients did not receive a respiratory review within 24 hours of admission.

- A patient does not receive a discharge bundle to support the discharge process and ongoing management of their COPD. 8% of patients did not receive a discharge bundle.

Managers and staff used the results to improve patients' outcomes and care and treatment. We saw that the increasing trend in patient falls had been identified but noted a significant reduction following the introduction of falls avoidance information given to all patients on admission and regular discussion of falls as part of the newly implemented safety huddle. Wards had developed signage to indicate the number of days since the last patient fall and staff commented that having visual aids reflecting performance had encouraged staff to sustain improvements.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Staff and senior leaders outlined the usage of their electronic system, which allowed staff to complete relevant clinical audits. We saw that the service had a comprehensive audit programme.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time.

Managers shared and made sure staff understood information from the audits. We saw examples of how audit results had been shared with staff through email and in safety huddles

Improvement is checked and monitored. We saw that all audit results had planned reviews and specific staff allocated to oversee the ongoing monitoring.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work. The trust provided newly qualified nurses and international nurses were with a preceptorship period.

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

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff we spoke with confirmed that there was a system in place to ensure staff received an annual appraisal. The current compliance rate for appraisals for medical staff was 87% and 85% for nursing and midwifery staff trust wide.

Managers supported nursing and medical staff to develop through regular, constructive clinical supervision of their work. The division was focused on performance appraisal and development reviews (PADR) for junior doctors looking to provide additional supportive measures to increase compliance in training overall.

The clinical educators supported the learning and development needs of staff.

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

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers told us that as part of their appraisals and supervision they would identify training or development needs for their staff and encourage them to pursue additional opportunities to improve.

Medical care (including older people's care)

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. All staff told us that managers were keen to assist staff to develop within their roles.

Managers made sure staff received any specialist training for their role. All staff told us that they were given ample opportunities to undertake further training and competencies for their role.

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We saw there were daily multidisciplinary team (MDT) meetings on each of the wards, attended by a range of nursing and medical staff, clinical support workers, pharmacy staff, occupational therapists and physiotherapists. These meetings included discussions about patients' conditions and needs, clinical care and discharge planning. We observed an MDT meeting and saw that all staff had an input into care and contributions were valued.

Staff worked across health care disciplines and with other agencies when required to care for patients. Allied health professionals including occupational therapists, physiotherapists and speech and language therapists all provided care as part of each ward team and contributed to patient records. They participated in safety huddles on each ward.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. We observed an example of a referral during inspection, staff told us the psychiatric liaison team were efficient in streaming referrals to ensure patients were seen and reviewed quickly.

Patients had their care pathway reviewed by relevant consultants.

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends. Patients are reviewed by consultants depending on the care pathway. We reviewed the notes of 32 patients and found they all had a clinical assessment undertaken by a consultant as required within 12 hours of admission. At weekends, there was an on-call rota, and access to consultants present onsite.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Key diagnostic tests (such as scans) could be undertaken seven days a week with urgent cases seen out of hours and at weekends. Medical staff we spoke to told us there was good access to diagnostic services. The service offered seven-day 24-hour discharge and the pharmacy was open seven days a week.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards. Wards we visited had lots of information available for patients on leaflet racks.

Medical care (including older people's care)

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Patients were screened on admission for smoking and alcohol intake as part of the admission pathway and offered advice on cessation.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They did not always use measures that limit patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care, however this was not always recorded. We observed during our inspection staff completing a Daily Mental Health Risk Assessment for patients, which prompted staff to consider patients capacity as a part of this. We noted within patients records that where questions had been raised regarding a patient's capacity, this had been noted – but when considering an application for Deprivation of Liberty Safeguards, staff did not always implement Deprivation of Liberty Safeguards in line with approved documentation. We observed three examples where patients had been subjected to a DOLS order but did not have corresponding capacity assessments and/or a decision recorded in the patients' best interest.

Staff gained consent from patients for their care and treatment in line with legislation and guidance and made sure patients consented to treatment based on all the information available Staff clearly recorded consent in the patients' records. We observed numerous examples throughout all patient notes we reviewed where consent had been sought appropriately to enable safe care and treatment.

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

Nursing and medical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. We reviewed the most recent Mental Capacity Act and DoLS training report, which outlined training compliance was above the trust target of 90% for all Medical specialities.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff we spoke with were able to provide a concise and accurate summary of the key principles relating to this legislation.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. We observed during our inspection staff members in dialogue with the trust's psychiatric liaison team, and staff outlined how they could access further information via the intranet.

Is the service caring?

Good ● ↑↑

Medical care (including older people's care)

Our rating of caring significantly improved. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed many interactions between staff, patients and others (for example carers and relatives) during our inspection. We found all staff to be polite, respectful, professional and non-judgmental in their approach.

Patients said staff treated them well and with kindness. Staff of all grades introduced themselves to patients, and asked what patients preferred to be called. We observed staff responding to patients' needs in a compassionate and timely manner; the patients we spoke with all had call bells available and those that had asked for assistance said they had not waited long before a member of staff attended. Staff conducted regular comfort rounds to assess patients' needs, such as if they required assistance to the toilet, if they were comfortable and if they would like anything to eat or drink

Staff followed policy to keep patient care and treatment confidential. Patients bed curtains were drawn when providing care and treatment and nursing and medical staff spoke with patients in private to maintain confidentiality.

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

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

Emotional support

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

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

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We saw that patients were well supported emotionally, and staff were caring and empathetic. There was a room available on the wards we visited for the use of patients and families and for staff to hold discussions with patients if they were distressed.

Staff told us that they had completed training on breaking bad news and demonstrated empathy when having difficult conversations. We requested details of mandatory and role specific training provided to staff and noted that there was no formal recording of breaking bad news training captured within these records. We were unable to review any documentation that supported staff's comments regarding this training.

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

Medical care (including older people's care)

Understanding and involvement of patients and those close to them

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

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

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

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

Staff supported patients to make advanced and informed decisions about their care.

Patients gave positive feedback about the service. We saw multiple examples of positive feedback received on all wards we visited.

Is the service responsive?

Requires Improvement ↑

Our rating of responsive improved. We rated it as requires improvement.

Service planning and delivery to meet the needs of the local people

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

Managers planned and organised services, so they met the changing needs of the local population.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. There had been no breaches of the standards for mixed sex accommodation at this site over the past 12 months.

Facilities and premises were appropriate for the services being delivered.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. Staff told us they had good communication systems in place with the mental health team to ensure timely intervention. We observed staff contacting the team during our inspection and noted a prompt arrival of the mental health team onto the ward.

The service had systems to help care for patients in need of additional support or specialist intervention. Due to staffing shortages, additional one to one care was not always fulfilled on the day case unit and urology ward, however staff took action to mitigate against potential risks by cohorting patients. We saw that staff had access to additional specialist equipment such as bariatric hoists and chairs.

The service relieved pressure on other departments when they could treat patients in a day.

Medical care (including older people's care)

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

Not all wards were designed to meet the needs of patients living with dementia. We raised this at the time of inspection, and we were told that there was an ongoing programme of work to refurbish the wards and that the refurbishment plans included making the wards meet the needs of patients living with dementia.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. The service had introduced a flag system within the digital platform to enable staff to identify patients with dementia. We saw several examples of the 'This Is Me' document being used by staff on the wards we visited.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences. We observed a meal service during inspection and saw examples of differing food options available.

Staff had access to communication aids to help patients become partners in their care and treatment.

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. However, given the significant strain on capacity in services it was not always possible to do this.

We inspected the pathway of medicine patients from admission in accident and emergency/GP referral to point of discharge. Patients were assessed on admission to determine what treatment pathway was required. There were differing pathway options available within the medicine speciality.

The hospital had significant capacity problems due to the high number of patients who had the no right to reside and there was no care package immediately available for discharge to be carried out safely. The situation was made worse by the complexities of COVID 19 pathways and keeping some patients isolated. Staff were required to monitor the number of delayed discharges and look at how to manage these effectively. The trust had failed to meet any of the cancer two week wait targets in the previous 12 months. Overall trust referral to treatment times (RTT) were worsening with only 64% compliance in August 2022 compared with 72% in September 2021. We requested specific service and specialty data but this was not available.

Medical care (including older people's care)

Managers and staff worked to make sure patients did not stay longer than they needed to. Senior leaders were aware of the pressures within the service. Managers and clinical leaders participated in site meetings held regularly throughout the day, every day. During these meetings managers discussed the number of patients waiting to be provided with beds within the service, the number of discharges planned for patients, and plans on how to manage shortfalls between the two. The average length of stay for the medical division was 17 nights on average for the past three months

The service moved patients only when there was a clear medical reason or in their best interest.

The average number of transfers that took place during the night over the past three months was 151. It was recognised as adding stress and anxiety for patients if they were moved. Staff tried not to move patients between wards at night. Patients were allocated beds throughout the night with planned moves to take place the following morning. However, staff told us this was not always possible due to the high demand on beds and sometimes patients were moved between wards at night.

Managers monitored that patient moves between wards were kept to a minimum.

Managers and staff started planning each patient's discharge as early as possible. Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. At the time of the inspection, there were a total of 50 patients who were medically optimised and fit for discharge. Patients were waiting for a package of care, a discharge to assess bed in the community or continuing healthcare assessments to progress their discharge. There were many patients waiting for community hospital beds for rehabilitation after an acute illness and these patients had complex needs with most wanting to return to their own home. Due to complexities in assessing patients who needed onward care, and the lack of care packages available to be purchased or arranged by social services, there were delays in discharging patient's home. The staffing shortages in adult social care had a detrimental effect on the whole system of access and flow for medical care. Significant pressures on partner organisations for home care & domiciliary care, resulted in significant discharge delays.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the highest number and took action to prevent them. A delayed discharge occurs when a patient, clinically ready for discharge, cannot leave hospital because the other necessary care, support or accommodation for them is not readily accessible and/or funding is not available. Barriers to timely discharge included transport delays, completion of an electronic discharge summary, awaiting medication and implementation of care packages. We reviewed figures in relation to delayed discharges for the previous three months, which reflected that there had been a total of 52 delayed discharges on average during this period. This had a negative impact on access and flow.

Staff supported patients when they were referred or transferred between services. There were 8 patients delayed transfers of care at the time of our inspection, resulting in 18 days of delays for patients.

Managers monitored patient transfers and followed national standards.

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

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Medical care (including older people's care)

Patients, relatives and carers knew how to complain or raise concerns. Staff were proactive in asking for feedback. We saw feedback boxes on each ward we visited but signage was inconsistent. We requested from the trust information regarding the number of open complaints at the time of inspection. There were a total of 20 active complaints, with 17 scheduled to be responded to in their agreed timescales and three that had been extended with agreement from the complaint. The average time to closure for complaints at the time of the inspection was 34 days.

The service did not always clearly display information about how to raise a concern in patient areas. We saw inconsistencies regarding displayed information on making complaints in any patient area that we visited.

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

Managers investigated complaints and identified themes. The division had identified three main categories in relation to complaints received about the service, these were communication with patients, a delay in diagnosis and a disagreement regarding diagnosis.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff told us that any learning from complaints would be discussed as part of their morning safety huddle, and that staff would also receive feedback on a case-by-case basis if they had been involved in the complaints process.

Managers shared feedback from complaints with staff and learning was used to improve the service. Managers shared with us examples of complaints that they had received and investigations and outcomes that came from them.

Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Requires Improvement ● ↑

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

Leadership

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

There was a clinical director for each speciality within the division, supported by nursing and operations directors, Deputies and then ward matrons and service managers.

We saw examples of leadership at site level with regard to communication with matrons and ward managers. Specific medical wards had differing leadership from onsite matrons. Staff told us they felt supported by matrons and senior nurses. Leaders we spoke with felt that they were visible. However, staff on the wards did not feel that there was leadership visibility aside from ward managers and matrons at local level.

Medical care (including older people's care)

We spoke with staff in leadership roles and they all described having been trained in leadership or having access to the trust's leadership programme. We saw from minutes of governance meetings we reviewed and from speaking with leaders that leaders understood the priorities and most of the issues the medicine service faced.

Vision and Strategy

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

Senior leaders had an annual workforce plan and were sighted with regarding overall recruitment of staff from nursing, medical and non-clinical staff. The division had highlighted speciality hotspots and the impact this would have on staff. The trust had an action plan in place to work towards in order to rectify individual concerns surrounding differing skill set.

We saw that the trust had various strategies to support it on delivering the strategic aims, including a quality strategy, a people strategy, and at department levels, operational strategies and business plans.

In addition, the trust had launched PROUD behaviours in June 2022 to further aid staff in embodying the trust's vision and values of Patient First, Respect, Ownership, Unity and Delivery. The values had been developed in consultation with staff and triangulated with various data sources such as NHS staff survey results. During the roll out phase, the trust undertook several engagement sessions with staff trust wide to embed the PROUD framework. Leaders have access to an activity pack via the trusts intranet page to facilitate discussions within teams about the behaviours and values at the heart of the framework.

Culture

Staff felt more respected, supported and valued since our previous inspection. They were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had a more open culture where patients, their families and staff felt they now could raise concerns without fear.

Staff told us there was an improved and more open culture. Staff told us that they felt confident to raise concerns with their managers. Staff members that we spoke with expressed their frustrations at the ward moves their team encountered due to short staffing across the division. Staff told us that staff shortages often impacted on the quality of patient care, and that staff felt they were not always able to provide high quality personalised care due to operational pressures.

Whilst staff commented that currently morale within the division was low, staff also spoke proudly of their colleagues and the hard work they encountered during the pandemic. Staff said they felt valued by their peers but felt there was a disconnect between clinical and executive staff.

We reviewed the most recent data and analysis relating to the NHS 2021 Staff survey. Due to the changes in the survey reporting comparisons can only be made to last year for the staff engagement and morale theme scores trust wide. Both scores had experienced a statistically significant decrease. The trust had agreed actions to address concerns relating to morale by generating a heat map of areas with lower morale that had been identified. People promise managers had

also been tasked to look at the correlation of morale on retention by holding focus groups and reviewing retention data such as exit interviews surveys and feedback from engagement interviews.

Staff survey results were shared as they were received into the division and individual areas had the opportunity to review and discuss their specialty results. The division reviewed the most recent staff survey and identified the key areas. The division work closely with human resources, occupational health, organisational development, and the freedom to speak up guardian to ensure staff had opportunities to share feedback and were signposted to appropriate support where necessary.

Staff in leadership positions spoke highly and with pride about their teams working on the wards.

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff at all levels had greater clarity about their roles and accountabilities and had regular opportunities to meet and discuss regarding the performance of the service, learning was not always identified and implemented.

The medicine division had a clear governance framework with staff assigned specific roles that ensured quality performance and risks were known about and managed.

We found a examples on inspection where processes were not undertaken in line with trust and national guidance which had been highlighted as concerns at the previous inspection. We identified ongoing issues in relation to the completion of mental capacity documentation, the use of restrictive interventions and training in relation to this, secureness of patient records, reporting of incidents. Whilst improvements and actions had been implemented, we were not assured that leaders had addressed all the key concerns highlighted at the last inspection or had sufficient oversight of their progress to date. This was reflective of what we found during this inspection. Whilst the division had made improvements in areas such as the management of deteriorating patients, further work was required to embed improvements and actions. In addition, we were not assured that processes to both review existing and identify new potential areas of risk were robust.

The service had a series of reports feeding into key meetings within the division, demonstrating the use of performance information to allow oversight and governance of improvement work such as the use of the Safety, Risk and Quality (SRQ) Dashboard. The reporting process was reviewed and discussed at a number of forums including medicine safety committee, medicine governance and ward managers meetings.

We reviewed the minutes of the divisional clinical governance meetings. Items were aligned to the integrated performance report so that local leaders and the board were aware of the same issues and risks. We noted discussion such as mandatory training, IPC, risk, appraisals, complaints, incidents, and performance were considered at the meetings.

Management of risk, issues and performance

Leaders and teams had systems to manage performance. They did not always identify relevant risks and issues. Actions were identified in some instances to reduce the impact of risks, however these were not always reviewed in a timely manner. They had plans to cope with unexpected events.

The leadership team were aware of their main risks and could explain the actions in place to mitigate their risks. Risks were identified and discussed and escalated for consideration for inclusion onto the risk register via divisional

governance meetings.

Risks were clearly described on the divisional risk register with clear actions taken to reduce or manage the risk, but these were not always reviewed in a timely manner. We reviewed copies of the risk register for all medical specialities and noted examples where risks included on the register were overdue for review, such as the Integrated Stroke and Geriatric medicine risk register were we noted the following;

- 21 High level risks - 9 overdue for review
- 24 Moderate level risks - 12 overdue for review
- 29 Low level risks – 19 overdue for review
- 14 risks due for review in the next 8-60 days

The trust had a comprehensive policy and supporting procedure that could be enacted to enable business continuity. Staff had access to flow diagrams that provided a key overview of the business continuity plan.

We saw governance boards on individual wards which displayed monthly governance and risk information updates. The information included individual wards top three incident themes, falls and pressure ulcer statistics, three things that had gone well and learning from incidents. The boards also included messages for sharing, patient feedback, three things individual wards wanted to improve upon, staff achievements, mandatory training and staff appraisal compliance data. Individual wards also displayed weekly team huddle information. The information included highlights surrounding star of the week, wellbeing at work, team messages, what's new, hot topics, achievements and performance.

Information Management

The service collected reliable data and analysed it, however this was not always available at location level. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff were aware of their responsibilities in relation to data protection and making sure that confidential information was managed securely through annual information governance training, however we found patient information was not always secured appropriately on the wards. For example, notes trollies were left unlocked on all the wards we visited. In addition, data supplied post inspection by the trust was not consistently separated by location level and had been aggregated to give a trust wide view of the medicine division. It was unclear as to how the trust were able to identify any differentiations in performance at site level, and use this to drive performance at location level.

Staff could access information technology (IT) systems to record and view information such as test and x-ray results and patient records. Patient records were electronic, and many assessments were integrated into the trust's electronic patient record system. Staff we spoke with demonstrated they could locate and access relevant information and records to enable them to carry out their day-to-day roles.

Ward managers could access information on the electronic staff record which helped them manage their teams. This included information on staffing, staff sickness, mandatory training, and appraisals. The service managed and used information appropriately to support its activities. The website contained detailed information about the differing wards, site maps, innovation and how to book an appointment.

The trust submitted all data and notifications to external organisations but did not always do this in a timely manner.

Medical care (including older people's care)

We reviewed NRLS between October 2021 and August 2022 and found that incident report times were variable and not always timely. Out of 24990, incidents there were 917 reported 90+ days after the incident occurred. 196 of these had been graded as moderate and above. This meant that investigations, lessons learned and actions put in place to prevent reoccurrence were not timely.

Engagement

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

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We saw comment boxes and cards located on wards, which allowed visitors to provide direct feedback. The trust participated in the Friends and Family Test (FFT), however since restarting FFT in October 2020, the 95% positive score target has not been achieved by the trust.

The Patient Experience Team are currently reviewing which wards have returned the most cards and what impact, if any, this has had on individual scores and response rates.

Staff engaged through the staff survey where issues were reported, and a subsequent action plan was created to improve staff experience. The 2021 results reflected that this year had seen the lowest response rate for the past 5 years at 38.3%.

Learning, continuous improvement and innovation

Staff displayed commitment to improving services in light of previous inspection findings. The service had understanding of quality improvement methods and articulated a desire to utilise these moving forward.

All staff were committed to continually learning and improving services. Staff and senior leaders articulated various improvements that had been implemented as result of the previous inspection, and acknowledged that there was still further work required to improve services.

The service displayed ward information was displayed outside each ward on a Quality board. This gave key and candid information about the ward's performance, such as patient safety message of the month, improvement initiatives, IPC, risks and learning from incidents, to staff, patients and visitors. Staff received learning specific to their ward on notice boards which captured learning after significant events and safety reminders.

Surgery

Requires Improvement ● → ←

Is the service safe?

Requires Improvement ● ↑

Our rating of safe improved. We rated it as requires improvement.

Mandatory training

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

Staff received and kept up to date with their mandatory training. The overall training compliance for surgery was 93% against a trust target of 90%.

The mandatory training was comprehensive and met the needs of patients and staff. All staff spoke positively about the practice developers and how they improved access to training.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. All clinical staff told us that they were given opportunities to complete mandatory training and were able to claim back any time used outside of work.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers were alerted if staff were approaching expiry of existing training, we saw managers using a red, amber, green (RAG) system to maintain oversight of staff's training records.

Safeguarding

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

All staff received training specific for their role on how to recognise and report abuse. Training data provided demonstrated compliance was in excess of the trust target of 90% for most staff groups.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Not all staff had direct experience of making a safeguarding referral but all staff we spoke with knew how to make a safeguarding referral and who to inform if they had concerns. All staff could identify the safeguarding lead within the organisation.

Children were not currently permitted to visit on the wards except in exceptional circumstances, but staff could articulate safe procedures if children were visiting the ward.

Surgery

Cleanliness, infection control and hygiene

The service still did not consistently control infection risk well. Staff did not consistently use equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

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

In line with national guidance from NHSE/I Estates PLACE environmental audits were suspended for the last two years, no results for 2020/21 were therefore available. We did see local ward cleanliness audits that had been completed and all wards were consistently above the trust target of 95%.

Staff used records to identify how well the service prevented infections.

Staff worked effectively to prevent, identify and treat surgical site infections. All wards met the trust target of 100% prevention of surgical site infection (Post-operative) and prevention of surgical site infection (Pre-operative). Surgical site infections were consistently beneath 1% for the last 12 months.

Staff did not always follow infection control principles; we saw multiple examples of staff across all roles and grades and across all surgical wards not correctly wearing personal protective equipment (PPE).

Staff told us that they cleaned equipment after patient contact but there was inconsistent use of 'I Am Clean' stickers as per trust policy. We saw examples across all wards of either no stickers, or with outdated information recorded.

Following inspection, we requested infection prevention and control (IPC) audits, these showed issues with hand hygiene compliance across the directorate, especially on wards G1, N2 and F1 where the target for compliance was not consistently achieved in the reporting period of April 2022 to September 2022. Ward G1 achieved compliance in one month in the reporting period and N2 and F1 only achieved compliance in three and four months respectively. We also noted that there was an inconsistent approach to when a ward would receive an audit. Ward G1 had been audited once a month for four months whilst F1 had been audited seven times. This had been recognised as an issue prior to inspection and it featured within the trust's improvement plan.

Environment and equipment

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

Patients could reach call bells and staff responded quickly when called. We saw during inspection that staff responded quickly when patients requested assistance.

Staff carried out daily safety checks of specialist equipment. We saw that daily safety checks were undertaken and recorded. We reviewed records and saw no omissions in the completion of records.

The service had enough suitable equipment to help them to safely care for patients. Staff told us that they had enough equipment to do their job properly. We were also told that any replacements were ordered from the equipment library and delivered promptly.

The resuscitation trolleys were situated on each ward and were all stocked correctly. We reviewed all check lists completed by staff and saw no omissions or errors.

Surgery

Staff disposed of clinical waste safely. We saw all clinical waste sharps bins were used and stored in accordance with national guidance.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. We saw that the National Early Warning System 2 (NEWS2) system was being used and that there was clear evidence within all patient records that we reviewed that it was being utilised effectively.

At the last inspection there was evidence of patients not being escalated appropriately with medical review being regularly omitted, at this inspection we saw that they was a designated doctor for all deteriorating patients to ensure that patients were seen appropriately.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. In all 30 records that we reviewed we saw assessments for the risk of pressure area damage, falls, malnutrition and venous thromboembolism (VTE). We saw evidence of staff using risk assessments when things had changed for a patient and making adjustments based on that information.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). Staff told us that the links with the mental health team were very good and that they could rely on a prompt response if they were worried about a patient.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. We requested the records of any patient with mental health issues and we saw all appropriate risk assessments had been completed appropriately.

Shift changes and handovers included all necessary key information to keep patients safe. We observed handovers across all wards and observed that all used Situation, Background, Assessment and Recommendation (SBAR).

Since the previous inspection there have been seven never events in theatres across both trust locations which highlighted issues with the completion of surgical safety checklists. At this inspection we observed improved practice and local audits received post inspection demonstrated that there was improvement towards 100% compliance.

At the previous inspection they were concerns regarding the sharing of key information to keep patients safe when handing over their care to others. At this inspection we saw that all wards had introduced safety huddles for the sharing of key information. We observed a number of huddles across different wards and we observed a consistent approach which included the same key areas of information.

Nurse staffing

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

The service had enough nursing and support staff to keep patients safe. We were told that following the previous inspection there had been a significant recruitment in numbers of overseas nursing staff which had a positive impact.

Surgery

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

The ward manager could adjust staffing levels daily according to the needs of patients. Staff were moved between wards according to the acuity of patients and any increased need.

The number of nurses and healthcare assistants matched the planned numbers. We saw minimal differences across all wards in planned staffing numbers versus actual staffing numbers.

The service had a nursing retention rates of 89% in excess of trust target of 85%.

The service had low turnover rates. The trust target was less than 10% and current turnover was 8%.

The service had a gradual increase in sickness rate from 2% to 4% in the last 12 months, this was still within trust targets.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers told us that permanent ward staff usually took any available additional shifts which was preferred as it maintained continuity of care for the patients.

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

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The Trust was unable to provide detailed vacancy information covering a defined period of time. This was due to the rotational movement of the junior doctor workforce resulting in vacancies spreading over a number of specialty areas.

Sickness rates for medical staff were 4%.

The medical staff matched the planned number. We spoke with five doctors across the hospital who told us they felt well supported by their senior team members and were able to access advice and peer support as they required it.

Doctors were supported by the 'hospital at night' system with three advanced nurse practitioners and two support workers who could help with tasks such as cannulation and taking bloods.

Senior clinicians and consultants we spoke with said there was no shortage of junior doctors on the wards.

We saw on the wards we visited sufficient numbers of medical staff to meet the needs of patients.

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

Records

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

Surgery

Patient notes were comprehensive, and all staff could access them easily.

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

Records were not always stored securely. We saw examples of computers being unlocked and left unattended. We also saw unlocked and unattended medical notes trolleys.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. Medicines were not always stored securely.

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

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. We saw pharmacists on the wards speaking with staff and patients. We were told that there was a pharmacist available 24 hours a day for advice.

Staff completed medicines records accurately and kept them up to date. We reviewed prescription charts in 30 sets of patients notes and found no errors or omissions.

Staff stored and managed all medicines and prescribing documents safely. We saw that all medicines were stored appropriately and securely.

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

Staff learned from safety alerts and incidents to improve practice. Safety alerts would be discussed during safety huddles to ensure all staff were aware of them. We were also told that safety alerts were sent by email to all staff.

At the previous inspection there had been issues surrounding the use of rapid tranquilisation. At this inspection the service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. All staff were aware of the changes to the trust rapid tranquilisation but none of the staff we spoke with had any direct experience of this being required.

At the last inspection there were issues with the storage of oxygen bottles, at this inspection we saw oxygen bottles being stored inappropriately. There were examples of unsecured bottles on the wards and within storage areas, this posed a safety risk to both staff and patients.

We observed controlled drugs (diamorphine) in theatres that had been drawn up and left unattended in an unsecure area which any member of staff could access and we saw two examples of controlled drugs (fentanyl) not having two signatures prior to removal from storage which was not in accordance with best practice.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Surgery

Staff knew what incidents to report and how to report them. All staff reported a culture of openness with incident reporting. Everyone felt that it was a positive and not punitive process with every member of staff encouraged to report incidents.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. Staff could give multiple examples of incidents that they or colleagues had reported.

The service had no never events on any wards. At the time of inspection there had been seven never events in theatres since the previous inspection.

Staff reported serious incidents clearly and in line with trust policy. Staff could articulate what would constitute a serious incident.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We reviewed three responses to incidents and saw that all obligations under duty of candour were met.

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

There was evidence that changes had been made as a result of feedback. At the previous inspection there had been a theme identified through incident reporting of increased patient falls. At this inspection we saw across all wards that falls prevention information and on slip socks were provided to all patients.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us that they would receive initial feedback from reporting and incident and further feedback would be provided once the incident had been investigated. We noted that not all staff were able to give examples of any incidents that had happened elsewhere.

We were not assured that all managers shared learning about never events with their staff and across the trust. All theatre staff were aware of the never events, but no ward staff knew that they had occurred, and no shared learning was apparent.

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good.

Surgery

Evidence-based care and treatment

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

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

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. We reviewed medical records of patients currently subject to the Mental Health Act and saw all documentation completed without omission or error.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We saw that this was a fixed point in the newly introduced safety huddles.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. All patients spoke positively about food choices and quantity of food provided. We saw that any additional dietary or hydration needs were consistently covered in all ward safety huddles and was a fixed point to cover. We also saw the use of a colour coded system to identify varying dietary needs.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. We reviewed 30 sets of patient care records and saw no omissions or errors in the completion of diet and fluid records.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We reviewed 30 sets of medical notes across the directorate and found that all records had a completed malnutrition risk assessment.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. There were issues around patients receiving specialist support over the weekend, but staff were able to describe the mitigation in place.

We saw examples of different dietary needs being met. We saw religious, cultural and specialist options as well as such as low salt, low fat or a softened consistency.

Staff told us that patients waiting to have surgery were not left nil by mouth for long periods. We requested any completed audits, but none had been undertaken.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way but did not audit the effectiveness of the assessment. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Surgery

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. We saw in all patient records that we reviewed that pain scores were accurately recorded. We also noted alternative methods of assessing pain scores were used, we observed the Wong-Baker system in use on all wards.

Patients received pain relief soon after requesting it. All patients reported prompt pain relief and no patient reported being left in pain.

Staff prescribed, administered and recorded pain relief accurately. We saw no errors or omissions in the patient records that we reviewed.

We requested any completed pain audits, but none were provided.

Patient outcomes

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

The service participated in relevant national clinical audits.

Outcomes for patients were positive, consistent and met expectations, such as national standards.

Managers and staff used the results to improve patients' outcomes. We saw action plans that had been created following participation in national audits to monitor and continue positive outcomes for patients.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. We saw that since the last inspection the service had introduced a largely comprehensive audit programme, but it did have some significant omissions such as pain.

Managers used information from the audits to improve care and treatment. We saw that the increasing trend in patient falls had been identified but noted a significant reduction following the introduction of falls avoidance information given to all patients on admission.

Managers shared and made sure staff understood information from the audits. We saw examples of how audit results had been shared with staff.

Improvement is checked and monitored. We saw that all audit results had planned reviews and specific staff allocated to oversee the ongoing monitoring.

Competent staff

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

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

Managers gave all new staff a full induction tailored to their role before they started work. All staff across differing roles and grades spoke positively about the induction process.

Managers did not always support all nursing staff to develop through yearly, constructive appraisals of their work. Compliance data provided following inspection showed 100% appraisal compliance for all ward-based staff but compliance in theatres did not achieve the required target in any area with the theatre admissions unit only achieving 36% compliance.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Appraisal completion compliance across medical staff was 84% and whilst this was beneath trust targets it demonstrated an improvement from our last inspection.

The clinical educators supported the learning and development needs of staff. Staff reported overwhelmingly positive experiences with the practice developers.

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

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers told us that they would identify training or development needs for their staff and encourage them to pursue additional opportunities to improve.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. All staff told us that managers were keen to assist staff to develop within their roles.

Managers made sure staff received any specialist training for their role. All staff told us that they were given ample opportunities to undertake further training and competencies for their role

Managers identified poor staff performance promptly and supported staff to improve. Managers told us how they would assist a member of staff to improve, they detailed supervised practice and additional support whilst on shift and ensuring that they received all necessary training for their role.

Multidisciplinary working

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

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

We observed a multi- disciplinary patient review meeting and saw proactive contributions made by all members of the patient care team which included consultants, junior medical staff, radiologists and nurse specialists.

Allied health professionals (AHPs) worked closely with ward staff, junior doctors and pharmacists on most wards we visited. For example, a rotational physiotherapist on an integrated ward had working hours to match the nursing staff.

Staff on the colorectal ward could access a surgical physiotherapist overnight and at weekends for patients who needed urgent chest physiotherapy or were at risk of deterioration. We heard about weekend physiotherapist referrals for laparotomy patients at the surgical assessment centre (SAC) alongside cover arrangements for occupational therapists and none therapy staff trained to undertake therapy assessments.

Surgery

Allied health professionals including occupational therapists, physiotherapists and speech and language therapists all provided care as part of each ward team and contributed to patient records. They participated in safety huddles on each ward.

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends. Patients are reviewed by consultants depending on the care pathway. In general surgery and urology there is a 7 day a week consultant led - post take ward round. All South Yorkshire regional services (SYRS) services have seven-day consultant ward rounds and on-site cover.

Staff told us patients were reviewed by consultants depending on the care pathway. The service offered seven-day 24-hour discharge and the pharmacy was open seven days a week.

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

Health promotion

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

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

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Staff we asked gave patients information on managing their diabetes, pressure area care and smoking cessation to raise awareness and patients could be referred for smoking cessation support upon discharge.

Patients could be referred for substance misuse detox programmes where appropriate.

Wards we visited had lots of information available for patients on leaflet racks.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

At the previous inspection we saw that managers did not always monitor the use of Deprivation of Liberty Safeguards (DoLS) and did not make sure staff knew how to complete them and that staff did not always understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005.

At this inspection we saw that all managers monitored the use of DoLS and ensured that staff knew how to complete them. All staff were able to articulate their role and responsibilities and they all demonstrated understanding of the process. They could also tell us who they could seek advice and guidance from.

Surgery

At the previous inspection we saw that cognitive assessments for patients with dementia had not been completed. At this inspection we specifically requested records of patients with dementia and we saw completed cognitive assessments in the six records that we reviewed.

Since the last inspection the trust had introduced ward assurance visits and assurance was provided following these visits that all surgical wards were following best practice. We reviewed the assurance visit documentation and saw that it was completed with no errors or omissions and that all wards were compliant.

We reviewed five sets of notes where a patient was subject to DoLS and we saw no omissions or errors in any of the paperwork completed.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We saw completed examples of capacity assessments within patient notes.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed staff seeking verbal consent before any interaction and we also saw consent being recorded appropriately.

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

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

Nursing staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. We were only provided with the training compliance at trust level which for nursing staff was 94% in excess of the trust target of 90%.

Clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. We were only provided with the training compliance at trust level which for clinical staff was 85% compared to the trust target of 90%. We did note that this was an improving picture.

Is the service caring?

Good ↑

Our rating of caring improved. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness.

Surgery

Staff followed policy to keep patient care and treatment confidential.

Feedback from people who used the service and those who were close to them was mixed. The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The trust provided Friends and Family Test data gathered from all surgical wards which ranged from 63% to 96%. The trust had completed additional work to understand the factors affecting those wards where the score was beneath trust target and we saw an improving picture. It was noted that the number of responses greatly varied with less responses on those wards scoring less highly.

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

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

Emotional support

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

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

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

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

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

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. We saw interpretation services were readily available on all wards

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We noted that staff had access to communication cards if required.

Staff told us that patients and their families could give feedback on the service and their treatment and staff supported them to do this. We did not see any information displayed in patient areas detailing how to give feedback or to make a complaint.

Staff supported patients to make advanced decisions about their care.

Staff supported patients to make informed decisions about their care.

Surgery

Patients gave positive feedback about the service. We saw multiple examples of positive feedback received on all wards we visited.

Is the service responsive?

Requires Improvement ➔🡐

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

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the needs of the local population.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. No ward staff could tell us when they last had a mixed sex breach.

Facilities and premises were appropriate for the services being delivered.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. Staff told us they had good communication systems in place with the mental health team to ensure timely intervention.

The service had systems to help care for patients in need of additional support or specialist intervention. We saw that staff had access to additional specialist equipment such as bariatric hoists and chairs.

Managers monitored and took action to minimise missed appointments.

The service relieved pressure on other departments when they could treat patients in a day. We saw that day surgery was offered for certain procedures which meant that admitting patients overnight would not be required.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. We saw several examples of the 'This Is Me' document being used by staff on the wards we visited.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Surgery

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. All staff were able to tell us where they could access these resources.

Patients were given a choice of food and drink to meet their cultural and religious preferences. We saw that different diets were available such as halal and kosher.

Staff had access to communication aids to help patients become partners in their care and treatment. We saw communication cards on several wards that we visited.

Not all wards were designed to meet the needs of patients living with dementia. We raised this at the time of inspection, and we were told that there was an ongoing programme of work to refurbish the wards and that dementia friendly methods would be utilised.

Access and flow

People could not always access the service when they needed it nor receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

Managers monitored waiting times and but could not ensure patients could access services when needed and received treatment within agreed timeframes and national targets. The trust had failed to meet any of the cancer two week wait targets in the previous 12 months. Overall trust referral to treatment times (RTT) were worsening with only 64% compliance in August 2022 compared with 72% in September 2021. We requested service and specialty specific data, but this was not available.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. We saw that the trust cancelled on average one emergency service operation per month.

Managers and staff worked to make sure patients did not stay longer than they needed to. The average length of stay was three nights which was within the national average.

Managers made sure they had arrangements for surgical staff to review any surgical patients on non-surgical wards. We were told that the consultant team responsible for the patient would ensure that they received the care required but it was unlikely for a surgical patient to be on a medical ward and no staff could give an example of it recently happening.

Managers worked to minimise the number of surgical patients on non-surgical wards. At the time of inspection there were no surgical patients on any medical wards.

Managers worked to keep the number of cancelled operations to a minimum. We did note following inspection that cancelled elective operations were an ongoing concern with numbers increased over the previous 12 months. We did see that the trust had undertaken further work to remodel the elective surgery service to ensure that cancellations were reduced.

When patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. We saw that all cancelled surgery had been rebooked within 28 days.

Surgery

Managers monitored that patient moves between wards/services were kept to a minimum. Managers and ward staff told us that patients were only generally moved if they needed to be located within a specialist area. We requested information regarding inpatient transfers, but this information was not recorded.

Staff told us that they tried not to move patients between wards at night. Data provided following inspection highlighted that an average of two patients were moved at night.

Managers and staff started planning each patient's discharge as early as possible. Staff told us that discharge planning started when the patient was admitted

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Discharge planning featured within all multidisciplinary team meetings.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. The average number of delayed discharges per month were 38, this had a negative impact on access and flow.

Staff supported patients when they were referred or transferred between services.

Managers monitored patient transfers and followed national standards.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received but the information on how to do so was not easily accessible. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Staff were proactive in asking for feedback. We saw feedback boxes on each ward we visited but signage was inconsistent.

The service did not clearly display information about how to raise a concern in patient areas. We saw no obviously displayed information on making complaints in any patient area that we visited.

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

Managers investigated complaints and identified themes. There had been 159 complaints made from September 2021 to August 2022 across both trust locations. The main themes were unhappy with outcome of surgery, communication with patient and waiting for procedure. At the time of inspection 26 were open with one overdue. The average time to complete the process was 44 days which was outside the trust standard of 40 days.

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

Managers shared feedback from complaints with staff and learning was used to improve the service. An example of changes made following complaints to improve the service was increased accessibility to telephone interpretation services.

Surgery

Staff could give examples of how they used patient feedback to improve daily practice. Patients had highlighted the risk of falling. We saw each ward provided falls prevention information and non-slip socks to all patients on admission.

Is the service well-led?

Requires Improvement ● ➔🡐

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

Leadership

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

Surgical services were separated into directorates so there were multiple leaders throughout the Trust. The theatre services managers had an overview of all surgery activity and the trust told us the medical director, Chief Operating Officer (COO) and deputy COO had overall leadership responsibility and were well sighted on all issues escalated to them.

Nursing leadership at ward level consisted of nurse directors who managed a team of matrons who managed two or more wards. These matrons managed nurses in charge of wards. Each care group had a Director of Nursing who reported to the Chief Nurse.

All staff spoke positively about senior leaders who reported that they were approachable and visible on the wards. Junior managers also spoke positively on how they were encouraged and supported to progress into more senior roles.

Vision and Strategy

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

The Chief Operating Officer and deputies had the overall vision for the organisation with networks between directorates all the time. The operations director for care group operating service, critical care and anaesthetics (OSCCA) had a clear insight of the vision and strategy regarding operating pathways for surgical directorates.

Managers told us each surgical directorate had its own vision. There were different strategies and vision for each directorate. We saw that the trust had submitted separate strategies for all surgical directorates. This was part of 'New Trust Corporate Strategy - Making a difference - the next chapter 22-27'. This described all the separate areas for improvement and innovation for the surgical directorates at the trust.

Culture

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

Surgery

All staff we spoke with told us that things were improving, and it was becoming a more positive environment to work in. There was an acknowledgement that things had been difficult for a number of years, but staff could see how things had been changing for the better.

All staff reported that everyone was there for the same reason and that was to ensure the best possible care for the patients.

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

Staff were able and encouraged to report incidents and make suggestions. They all reported being taken seriously and that their views were considered as valid as more senior staff.

All staff felt confident to raise concerns or to report incidents as they felt that it was not a punitive process and that incident reporting was used as a tool for learning.

Governance

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

The governance framework provided by the trust showed a range of trust wide groups and meetings that fed into governance processes. The trust provided minutes of governance meetings from several specialities which included information about performance, risks identified and engagement. Actions had been agreed and staff identified to address them.

We saw significant improvements since our last inspection in that the trust had implemented new systems to monitor compliance and had created new audits. These were not yet fully embedded, but the pace of change was positive.

Management of risk, issues and performance

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

We saw that the provider had a risk register which had all identified risks, dates of entry, dates for review, mitigations and staff allocated to manage each risk. We were assured that senior staff escalated risks where necessary.

We saw robust systems and processes were now being utilised to manage performance. We were assured that the senior management team had sufficient oversight of performance to identify areas that required improvement.

Staff told us that their opinions were sought by senior management when decisions were needed to be made.

The pace of action within theatres in relation to never events was a persistent issue which demonstrated that the work undertaken was not yet fully embedded.

Surgery

Improvements had been made since our last inspection, but we saw that there have been multiple areas where compliance towards trust targets has not been met such as in infection prevention and control audits and safety checklists in theatres.

Information Management

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

We saw that data was collected both at a national and local level, but we were not assured that it was always utilized in a timely manner to make improvements. We saw that data had been collected regarding ward infection prevention and control measures, but we saw no actions taken when compliance did not reach trust targets, this was particularly noted with ward-based hand hygiene compliance.

We were advised that audits continued until a ward had achieved compliance, therefore each ward had a different number of audits. We reviewed infection prevention and control audits and saw that over a seven-month period ward G1 had been audited four times whilst ward F1 had been audited seven times.

We saw that data was also collected in response to issues that had been highlighted through notifications regarding never events. We saw that work was undertaken to address the low compliance with surgery safety checklists. This work was still ongoing during inspection, but data submitted showed consistent improvement.

The trust submitted all data and notifications to external organisations when required.

Engagement

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

Staff were engaged through the surgical services staff survey where issues were reported, and a subsequent action plan was created to improve staff experience through the People Promise. We saw completed examples of these action plans and found them to include outcomes, measures, timescales and allocated to senior staff to oversee.

The Trust's patient engagement work was not site specific; the Trust had a patient experience group that oversees the trust's patient engagement activity and a quarterly report is then made available. In addition, the trust ran a patient first group which was made up predominantly of patients, governors and carers, and was co-chaired by two patients. A small number of staff attended to ensure that feedback from the group can be fed into programmes of work. The group acts as a reference group for gaining engagement in service developments.

Learning, continuous improvement and innovation

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

Surgery

All senior leaders were able to articulate the need for continuous innovation and improvement as well as understanding of quality improvement methods and the skills to use them. Examples given included improving cross professional group working with innovative treatments that have been introduced following a collaborative piece of work across specialities and specific improvements in vascular services which have improved patient care.

Care Quality Commission

Northern General Hospital

Herries Road
Sheffield
S5 7AU
Tel: 01142434343
www.sth.nhs.uk

Description of this hospital

The Northern General Hospital is one of sixteen locations where Sheffield Teaching Hospitals NHS Foundation Trust provides care.

During this inspection we inspected and rated the following core services at this location:

- Medicine (including older people's care)
- Surgery
- Urgent and emergency care

Urgent and emergency services

Requires Improvement ↑

Is the service safe?

Requires Improvement ↑

Our rating of safe improved. We rated it as requires improvement.

Mandatory training

The service now provided mandatory training in key skills including the highest level of life support training to all staff and made sure everyone completed it.

Nursing staff and medical staff received and kept up to date with their mandatory training. The trust provided data for mandatory and statutory training compliance rates for the acute and emergency medicine directorate. Overall, the trust target of 90% had been met.

The mandatory training was comprehensive and met the needs of patients and staff. The trust target for compliance with mandatory training was 90%. Most staff had completed most modules of mandatory and statutory training to keep patients safe. The service had met or exceeded the trust's target compliance rate for the 17 required training modules, with the exception of level three safeguarding children training and one of three modules focussing on fire safety. Whilst these two modules were below the trust's target, compliance had both improved since the last inspection and was above 80%.

The trust also had job specific essential training (JSET) and the target for compliance was 90%. Nurse staffing met the target in all of eleven modules.

Medical staffing met the target in one of the six modules. Whilst the other five modules were below the trust target, they were on target to meet compliance by December 2022.

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

Nursing staff had exceeded the trust target of 90% for completion of Mental Capacity Act training level 2a and Mental Capacity Act Deprivation of Liberty Safeguards level 2b.

Medical staff were on target to meet the trust target in both Mental Capacity Act level 2a and 2b.

Staff told us that they could access learning disability awareness and dementia e-learning training. At the time of the inspection the trust did not have any data on the uptake of this training. We saw staff attending the dementia training breakfast club whilst we were onsite. Managers told us that staff received training from offsite dementia specialists and micro teaching modules that they accessed via the education social media page.

The trust told us that all doctors in the Urgent & Emergency Department and all members of the crash team had Advanced life support training.

Nursing staff received training in basic life support (BLS) and compliance with this training was 94%. The trust told us that it was not mandatory for nursing staff to hold intermediate life support (ILS) and/or advanced life support (ALS) due to medical staff presence.

The department ran weekly simulations and a trauma of the week session where staff from all roles could learn together. Themes identified from incidences were covered at these sessions.

The trust had a revised sepsis policy which had been amended since our last inspection. This included the recognition of deterioration and red flag markers of sepsis and the addition of antibiotic review.

Managers monitored mandatory training and alerted staff when they needed to update their training. Senior managers sent regular emails to staff groups when training was due to be completed.

Safeguarding

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

Nursing staff received training specific for their role on how to recognise and report abuse. Nursing staff exceeded the trust target of 90% for training in safeguarding children and young people level 1 and 2. Level 3 training was below the trust target at 83%.

Medical staff received training specific for their role on how to recognise and report abuse. Medical staff were fully compliant in safeguarding children and young people level 3. Medical staff met the trust target for level 2 safeguarding adults.

The trust had a safeguarding adults policy in place which was in date and version controlled.

At the last inspection, the safeguarding children policy was out of date. This policy had been fully reviewed, updated with legislative and statutory guidance.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Safeguarding was a standard agenda item across the department. We observed safeguarding and issues being discussed at handovers and safety huddles.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff had training and were confident that they would recognise someone that was at risk. Staff were able to give examples of situations that they have raised/reported.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The trust had a designated safeguarding lead and a deputy. Staff knew who they were and who to contact them.

Cleanliness, infection control and hygiene

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

All areas were clean and had suitable furnishings which were clean and well-maintained. We saw regular continuous cleaning across the department and staff worked a rota 24 hours per day to provide domestic services to the department.

In line with national guidance from NHSE/I Estates PLACE was suspended for the last two years, no results for 2020/21 were therefore available. The trust told us that PLACE audits were to be recommenced at the beginning of October and results would be submitted at the end of November 2022. The trust provided IPC audits for the emergency department for 2021 and 2022. The trust scored 88% and 92% which was below the trust target of 95%. We found that they were completed inconsistently. Hand hygiene results were not available for February, July or August 2022.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Toilet cleaning checklist were completed hourly.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw that staff adhered to infection control practices and wore the correct PPE.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw multiple examples of staff cleaning equipment after patient contact within the department. Equipment was labelled to show when it was last cleaned appropriately.

There were designated areas for isolation that would be used for covid positive patients or patients diagnosed with a communicable infection.

We asked the trust to provide their infection prevention and control policy. The trust provided 46 policies. We reviewed the trust policy for infection control isolation precautions and patient placement policy, as the most applicable policy to patients attending the emergency department. At the last inspection this policy was past its due date for review, which was due on the 01 March 2016. The trust had not updated this policy.

Environment and equipment

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

Patients could reach call bells and staff responded quickly when called. All patients had access to call bells, and they were in reach of patients. We saw staff responded to call bells in a timely manner. Staff told us that call bells were now part of the falls risk assessment.

The design of the environment followed national guidance. The waiting area was in the main entrance to the department and had enough seats for patients. The seats faced the reception area, so patients were visible from the reception desk, and there was clear signage directing patients to other areas, including General Practitioners (GP) assessment.

The department had a mental health room which was which was minimally furnished with two heavy sofas. There was a strip alarm around the walls. The room was visible from the nurse's station and had a vistamatic window for observation. The room was designed to be ligature free, however during our visit we observed a smoke alarm in the

ceiling which appeared to have had some silicone applied but potentially would still be a ligature point risk. The door to the back of the room was alarmed, however allowed access straight into x-ray department where there was an exit door. We were told that they had been a recent absconsion from there and were not assured that this risk had been mitigated by the trust.

Staff carried out daily safety checks of specialist equipment. We reviewed the daily departmental checklists for each area. Daily checks were completed consistently across all areas of the department, including resuscitation equipment, medication rooms and fridges and PPE availability.

The service had suitable facilities to meet the needs of patients' families. There were two relatives' rooms in the department where families and loved ones could wait. One of the relatives' rooms gave direct access to the department's viewing room which meant families of patients who were bereaved could see their loved ones. There was a forget-me-not flower sign attached to the door when the room was in use to notify staff, and we saw this was used during the inspection.

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

Staff disposed of clinical waste safely. We saw all clinical waste sharp bins were used and stored correctly in line with national guidance.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients. This tool was used to assess physiological observations for every patient for whom a clinical decision to admit had been made and appropriately escalate deterioration in a patient's condition.

We reviewed 20 records of patients in the department during the inspection and all had their observations recorded in line with the local policy or national guidelines. In the examples we saw, patients' records showed National Early Warning Score2 (NEWS2) had been correctly calculated, and there was evidence of prompt escalation and medical review when required. The trust had a revised deteriorating patient policy which reflected current practice and guidance.

We spoke to 10 staff members who could describe the red flag markers for medical review of a deteriorating patient where sepsis might be indicated. The service had a deteriorating patient screening tool for escalation. We were told this ensured a prompt response from medical staff; we observed two examples of this happening during our inspection.

The trust provided a sepsis action plan 2022/2023 which outlined eight areas that they were working on. This included updating the guidelines and deterioration patient tool. Establishment of the deteriorating patient electric alert on the whiteboard and deterioration patient bleep across all areas of the hospital. Development of training and simulations run charts to measure time to check lactate and development of the sepsis dashboard. The trust did not provide any associated timescales to indicate when these areas would have the actions completed. We were not assured that the trust had oversight of the treatment of patients with identified sepsis.

Urgent and emergency services

We observed a nurse sister doing the intentional rounding following the quality and assurance checks on their board. Clear escalation pathways were documented. However, during the inspection, we did find gaps in recorded of intentional rounding in patient's records.

We observed good multidisciplinary team communication about deteriorating patients which were reviewed in timely manner.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Patients' risk assessments were completed on arrival where appropriate for falls look tool, react to red, Glasgow coma scale, (GCS), nutrition and hydration, and mental health. We saw evidence that these risk assessments were used to plan individuals care plans and refer into the relevant pathways.

Staff knew about and dealt with any specific risk issues. Staff received job specific essential training for the deteriorating patient, moving and handling, tissue viability and react to red.

The Trust had 24-hour access to mental health liaison and specialist mental health support. The mental health liaison team was based in the emergency department and provided mental health assessment and care to patients. The trust jointly worked with and referred patients to other services which were available to support the mental health needs of patients.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. We observed staff completing the daily mental health risk assessment when patients presented with mental health concerns including patients who may be at risk of self-harm or suicide.

We reviewed instances of the use of restrictive interventions from the 1st May to the 1st of September 2022 which showed there were 118 restrictive practice incidents logged on Datix trust wide. 17 of these were in the emergency department. We were not assured that staff documented and monitored the physical health of patients following rapid tranquilisation.

Each episode of restraint or rapid tranquilisation is reviewed at the weekly clinical governance huddle. Lessons were then shared with the team.

The service relied on security staff to assist in high-risk incidents where patients were highly aggressive or displayed violent behaviour. Staff did not have or were not aware of guidance for when to call for security staff to assist in managing an incident and security staff did not have clear guidance for how to prioritise responses to staff requests for assistance.

Security staff were required to provide one to one observations of patients presenting with high risks of violence, aggression or absconding. In incidents reports we saw security staff were required to restrain patients. However, security staff had not had the training required to manage restraint safely in a healthcare setting.

Staff shared key information to keep patients safe when handing over their care to others. There were regular nurse and consultant in charge huddles and nursing and medical handovers in the department. The nurse and consultant in charge monitored patients in the department using the e-whiteboard and patients arriving by ambulance using the electronic ambulance system. The whiteboard had information which gave the staff in charge oversight of the demands on the department, and it auto calculated the escalation score based on the department's activity.

Urgent and emergency services

Patients arriving to the department by ambulance were handed over to the Initial Assessment Unit (IAU). When this area was full, patients would wait in the back of ambulances. The nurse and consultant in charge of the shift kept oversight of patients in the IAU by monitoring the electronic whiteboard for signs of deterioration. The nurse and consultant in charge of the shift told us they kept oversight of patients waiting in the ambulance queue through paramedics escalating concerns, and when the wait was long, they completed a "ward round" of ambulance patients waiting. We were not assured that this was a robust process, and when the department was busy and understaffed, the nurse and consultant in charge were not always able to stay at their station to support the IAU.

Shift changes and handovers included all necessary key information to keep patients safe.

Since the last inspection, the trust had introduced a streaming nurse service from 7am to 7pm to direct patients towards other clinical services able to deal with their presenting symptoms instead of the emergency department. Patients were triaged and streamed to the following Same day emergency care (SDEC), GP Collaborative, Sheffield Walk in Centre, Minor Injuries service or Emergency Eye Centre at Royal Hallamshire Hospital (RHH). Data received from the trust showed that between March 2022 to June 2022 12 patients were streamed directly to resus due to the early intervention of the streaming service.

Nurse staffing

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

The service now had enough nursing and support staff to keep patients safe. We found planned and actual staffing levels were displayed within the emergency department when we visited. The department was staffed by qualified nurses and clinical support workers appropriately. We were told that following the last inspection there had been a significant recruitment of overseas nursing staff which had a positive impact.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Managers reviewed staffing and skill mix daily and took action to mitigate the risks in accordance with the nurse staffing escalation policy

The department manager could adjust staffing levels daily according to the needs of patients. We observed an operational meeting and safety huddles where matrons and senior staff discussed staffing and acuity levels daily. Staff were redeployed from other areas within the department at times of increased demand and acuity. The service accessed additional clinical support workers to help with one-to-one support when required.

The number of nurses and healthcare assistants matched the planned numbers.

The service had low vacancy rates.

The trust provided turnover rates. Data from March 2022 to August 2022 showed a turnover rate of 9.06%. This was below the trust target of 10%.

The trust provided data to evidence sickness from March 2022 to August 2022. Sickness rates were 6.98%. This was above the trust target of 4%.

The service had low and/or reducing rates of bank and agency nurses. We reviewed the sum of hours for agency and bank usage for the department. Data showed that from March 2022 to August 2022. Agency staff filled 1126 hours and bank staff filled 35498 hours.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers told us that permanent staff usually took any available shifts as overtime/extras or bank.

Managers made sure all bank and agency staff had a full induction and understood the service. All bank and agency staff are expected to complete mandatory training and job specific essential training before they commence work.

Medical staffing

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

The service had enough medical staff to keep patients safe. The emergency department had 24 whole time equivalent (WTE) consultants in post which was just below the recommendations for minimum consultant staffing according to the Royal College of Emergency medicine (RCEM).

Whilst we were onsite the medical staff matched the planned number.

The service had low vacancy rates for medical staff. The trust provided medical staffing vacancy rates. Data from August 2022 showed a vacancy rate of 5.5%.

The service had low turnover rates for medical staff. The trust provided turnover rates. Data from March 2022 to August 2022 showed a turnover rate of 2.69%

Sickness rates for medical staff were low. The trust provided data to evidence sickness from March 2022 to August 2022. Sickness rates were 5.11%.

The service had low rates of bank and locum staff.

Managers could access locums when they needed additional medical staff. The emergency department used locums' staff to cover weekend shifts.

The trust recently agreed to fund 3 locum shifts per day as additional to help cover nights and evening. This would commence November 2022 and run until April 2023. This was part of the department plan to respond to expected winter pressures.

Managers made sure locums had a full induction to the service before they started work. All locum staff are expected to complete mandatory training and job specific essential training before they commence work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. We saw evidence of a good skill mix on each shift which included consultants, middle grades, junior doctors, and advanced clinical practitioners (ACP).

Urgent and emergency services

The service always had a resident consultant during evenings and weekends. The trust had provision of 24-hour consultant cover in place. We reviewed four weeks of rotas and there was a consultant on duty every shift.

We spoke with a range of junior doctors who told us that they well supported within the department from consultants and doctors. There was a robust induction and good Interspeciality working especially with intensive care unit (ITU).

Records

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

Patient notes were comprehensive, and all staff could access them easily. The trust had an electronic information technology system for all nursing and medical records.

Patients that arrived by ambulance had key documents scanned on to their electronic patient record, however some staff we spoke with told us it was difficult to find the documents.

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

Records were not always stored securely. We saw examples of computers left unattended and unlocked, with smart cards insitu.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. The trust had an electronic system for prescribing and administering medicines.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. The department had 2 pharmacists that worked in the department Monday to Friday providing support and reviewing medicines.

Staff told us that critical medications were given to patients in the emergency department. Critical medications were not always in stock which could result in delays to the patient receiving it.

Staff completed medicines records accurately and kept them up to date.

Staff stored and managed all medicines and prescribing documents safely. There were appropriate, secure, storage facilities for medicines. Medicines storage rooms were secured by keypad access and all medicines cabinets, trolleys and fridges were locked in line with the providers policy. Controlled drugs were kept in separate locked cupboards and appropriate checks recorded. We saw records for electronic fridge temperatures, and all were within acceptable limits.

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

Staff learned from safety alerts and incidents to improve practice. Safety alerts would be discussed at safety huddles to ensure all staff were aware of them. We were also told that safety alerts were sent by emails and bulletins to all staff.

Urgent and emergency services

The service ensured peoples' behaviour was not controlled by excessive and inappropriate use of medicines.

Incidents

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

Staff knew what incidents to report and how to report them. Staff were aware of the importance of reporting incidences and how to report an incident using the electronic reporting system. We also spoke with 10 staff who were each aware of the incident reporting process and told us they were confident that incidents were dealt with appropriately.

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could give examples of recent reported incidents that had resulted in shared learning for the department. Managers shared monthly feedback to the team which included incident trends, top five risks and lesson learnt. Monthly datix themes were fed back to the team in a “you reported- we acted” poster during staff meetings.

The emergency department had no never events in the last 12 months.

Managers shared learning with their staff about never events that happened elsewhere.

Staff reported serious incidents clearly and in line with trust policy. Staff could describe what would constitute a serious incident.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Duty of candour was reflected in the investigation of incidents and was included in the emergency department governance executive agenda.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us that initial feedback and further feedback would be provided once the investigation had been completed.

Staff met to discuss the feedback and look at improvements to patient care. There was evidence that staff identified themes and looked at ways to improve. Patient falls were identified as a theme and the trust had implemented the Yellow to Red sock Initiative.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident. Senior members of staff told us that they held debriefs with staff after difficult or traumatic incidents in the department.

Managers shared learning with their staff about never events that happened elsewhere. Shared learning about incidents and never events that had happened elsewhere were shared via bulletins.

Urgent and emergency services

Is the service effective?

Requires Improvement ● ➔🡐

Our rating of effective improved. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on evidence-based practice, however policies were not all in line with national guidance and best practice. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed policies to plan and deliver care, however not all guidelines and policies were up to date or reflected best practice. Staff had access to policies, procedures, and guidelines on the intranet. Policies and procedures were evidence based on national guidance including National Institute for Health and Care Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff had received core training in consent, Mental Capacity and Deprivation of Liberty Safeguards as part of mandatory and statutory training.

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

Nutrition and hydration

Staff now ensured patients had enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

Drinks and snacks were available in the waiting room vending machines

Since our last inspection, the emergency department had increased housekeeper availability to provide 24 hour cover to support patients' nutrition and hydration needs.

We saw that hydrations stations had been set up in each area.

Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. We saw in all patient records that we reviewed that pain scores were documented.

Patients received pain relief soon after it was identified they needed it or they requested it. We observed the arrival of patients in the department and their triage assessment, pain relief was administered appropriately, and this was documented. We spoke with 10 patients and each of them had been asked if they were in any pain. Only three required pain relief and it was administered in a timely manner.

Staff prescribed, administered and recorded pain relief accurately.

We requested any completed pain audit results and action plan. The trust told us that the audit report was submitted to the Clinical Effectiveness Committee for approval then an audit report would be available. The results were not available at the time of the inspection.

Patient outcomes

Staff did monitor the effectiveness of care and treatment. They did not always use the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. The trust clinical audit programme (TCAP) was determined by the trust and directorate prioritises in line with the Healthcare Quality Improvement Partnership (HQIP). The acute emergency care directorate took part in several audits in 2021/2022 which included the RCEM audit on mental health, TARN (The Trauma Audit & Research Network) and audit of cervical spine management.

Data showed that in the RCEM Audit on Mental Health (Adult) 2020/2021 that the emergency department did not meet the fundamental standards that all patients should have mental health triage on arrival to briefly gauge their risk of self-harm or suicide and risk of leaving the department before assessment or treatment is complete.

Data from the Trauma Audit & Research Network 2020/21 showed there are variations in the success of treatment in different hospitals. It followed that there were opportunities to improve care.

Data from the Audit of Cervical Spine Management - Re-Audit 2020/2021 results showed no change in documentation of assessment of neck injuries, with neck rotation being the more poorly documented rule at 87% of cases.

Outcomes for patients were not always positive, consistent and did not always meet expectations, such as national standards. The department did not provide action plans following their clinical audit programme to outline how they would action to improve outcomes. We were not assured that the trust had oversight of monitoring actions and outcomes relating to audits.

Managers and staff did not always use the results to improve patients' outcomes. Clinical governance monitoring reports were prepared which reflected key performance indicators and patient outcomes. The department regularly monitored its performance against a range of clinical indicators through a performance dashboard.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The department had a planned comprehensive audit programme.

Managers did not always use information from the audits to improve care and treatment. Managers told us that audits were used to identify areas of learning and improvements. Results from audit were linked to the department's education and training programme

Managers shared and made sure staff understood information from the audits. Managers shared and made sure staff understood information from the audits using team meetings, safety huddles and newsletters.

Competent staff

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

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

Managers gave all new staff a full induction tailored to their role before they started work. The department had a comprehensive induction process. Staff that we spoke with were positive around the induction process.

Managers supported staff to develop through yearly, constructive appraisals of their work. The trust target for appraisals was 90%

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Nursing staff appraisal compliance was 78% which was below the trust target. However, this had improved since the last inspection. The trust should continue to improve compliance with appraisals for nursing and medical staff.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff appraisal compliance was 80% which was below the trust target.

The clinical educators supported the learning and development needs of staff. The department had a team of clinical educators that supported the development and learning of staff. Staff told us that the clinical educators had a strong presence across the department and were supportive. They had a comprehensive training programme.

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

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us that during appraisal and one to one supervisions training and development was a key area that was discussed. Managers encouraged staff to pursue additional opportunities to improve.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us that managers supported them to develop in their roles.

Managers made sure staff received any specialist training for their role. Specialist core competencies were available dependant on an individual's role. Staff were supported to complete and given protected time to achieve training.

Managers identified poor staff performance promptly and supported staff to improve. Managers told us they would support staff to improve, they undertook supervised practice and additional support whilst on shift.

Urgent and emergency services

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Different teams of healthcare professionals worked together as a multidisciplinary team (MDT). We observed a daily operational meeting which was led by the operational lead and attended by clinical leads, nursing staff and orderly lead.

We observed a daily safety huddle which was nurse led. Incidents, investigations and learning were discussed.

Medical and nursing staff worked well together. We observed the trauma team in resus during a patient assessment. Members of the trauma team from each speciality arrived quickly and were given information about the patient's condition from the pre-alert information. Each team member clearly identified themselves with the use of a name label. Equipment was prepared before the patient arrived. We observed staff as they discussed plans with each other and within the wider team. Multidisciplinary working was efficient and well organised.

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

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression.

Seven-day services

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

The emergency department was open 24 hours a day, seven days a week. Consultant cover was provided 24 hours a day in line with RCEM Workforce Recommendations 2018.

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

Health Promotion

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

The service had relevant information promoting healthy lifestyles and support on the department. The department had developed patient information leaflets as an online resource and there were posters with QR codes around the department so that patients could look at any leaflets that might be useful.

Staff assessed each patient's health when admitted and provided support for any individual needs. Referral pathways were in place for patients requiring the alcohol support service and we observed posters in the department with information about the service.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

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

Urgent and emergency services

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. The Mental Capacity Act and Deprivation of Liberty Safeguards were part of annual mandatory training for nursing staff and the department had achieved 80% compliance.

Mental capacity assessments were included in the electronic patient record which meant these were completed for each patient. Staff were each able to explain mental capacity assessment and the circumstances in which it was required.

Staff we spoke with were also aware of how they would access support from the on-site mental health team in the department.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. When patients did not have capacity to consent staff made decisions in their best interests.

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

Staff made sure patients consented to treatment based on all the information available. Staff we spoke with said verbal consent was obtained from patients prior to treatment. Consent would not usually be documented unless a patient refused.

Staff clearly recorded consent in the patients' record.

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

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

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

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff told us that they could access policies on the intranet.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

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

Is the service caring?

Good ↑

Urgent and emergency services

Our rating of caring improved. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. We saw that privacy screens and curtains when drawn when required to protect their dignity, including to use facilities, and when patients were being moved. This had improved since the last inspection.

Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff spoke kindly to patients and explained what was happening and what investigations/ treatment was needed. We spoke with one patient in resus who told us that the staff were lovely and had explained what was happening. They told us staff treat them with dignity and respect.

Patients said staff treated them well and with kindness. We observed staff introducing themselves by name and role to patients.

Staff followed policy to keep patient care and treatment confidential. In the initial assessment area (IAU) there was six beds and three chairs. We saw that curtains and privacy screens were used to give patients total privacy and dignity.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We observed staff interactions with three patients who had presented requiring mental health support, and each member of staff was kind, showed empathy and was understanding to their needs.

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

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff provided emotional support to patients by allowing them time to talk which gave them reassurance.

Staff told us that they had completed training on breaking bad news and demonstrated empathy when having difficult conversations. We requested details of mandatory and role specific training provided to staff and noted that there was no formal recording of breaking bad news training captured within these records. We were unable to review any documentation that supported staff’s comments regarding this training.

Staff demonstrated empathy when having difficult conversations. We saw the relative's room and viewing room in use during the inspection and staff were compassionate and respectful to families.

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

Urgent and emergency services

Understanding and involvement of patients and those close to them.

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

Staff made sure patients and those close to them understood their care and treatment. We observed staff across all areas of the department explaining to patients their plan of care and answering any questions that patients asked. We spoke with a family of patient in resus. They told us that staff had explained what was happening and updated them. `

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

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

The feedback from the emergency department friends and family survey data from February 2022 showed a positive response rate of 75%.

Is the service responsive?

Requires Improvement ➔🡐

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

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the needs of the local population.

Facilities and premises were not always appropriate for the services being delivered. The department's estate did not meet patient demand. We saw that overcrowding was an issue, however there was not enough capacity in the department to meet the needs of the numbers and acuity of patients accessing the service and there were significant waits for patients to be seen by nursing and medical staff.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. The department's mental health service provided assessments of patients who needed it, however there were often delays in finding placements when required. This was a system wide issue, and managers escalated long stay patients regularly.

The service had systems to help care for patients in need of additional support or specialist intervention. The emergency department had specialist link nurses to support the care and treatment of patients.

The service relieved pressure on other departments when they could treat patients in a day.

Urgent and emergency services

Meeting people's individual needs

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

Staff tried to ensure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The clinical decision unit was quieter than the main department and provided a calmer environment for patients. who had mental health problems or learning disabilities.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

When a patient identified at the ED as hard of hearing, the trust provided a hard of hearing sticker so that staff would be aware, and that the patient was identified as needing additional support.

The service had information leaflets available in languages spoken by the patients and local community. They had developed patient information leaflets online, which could be accessed using QR codes in the department and could be printed for patients who could not access them or required them in a different language.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The department had access to a telephone translation service. There was an -electronic device to be used if patients required face to face interpretation. There was instruction in the ED of how to use the service and a list of the most frequently spoken languages.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Access and flow

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

Managers monitored waiting times and made sure patients could access emergency services when needed. However, patients did not always receive treatment within agreed timeframes and national targets. The emergency department had seen an increase in attendances and waiting times for treatment, The trust did not meet national targets for admission to ward times.

The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. The trust did not meet the standard between April 2021 to May 2022.

The percentage of ambulance handovers completed within 15 minutes in June 2022 was 35.7% which had declined from 41.95% in June 2021. The percentage of ambulance handovers that took more than 30 minutes in June 2022 was 20.1%.

We also saw the department had long waits to see medical staff including up to 7 hours. This meant that the emergency department was under sustained pressure at times.

Managers and staff worked to make sure patients did not stay longer than they needed to.

The clinical decision unit was located adjacent to the department and formed part of the department. Patients could be admitted directly from the emergency department or through a primary care or clinic referral. The unit provided ambulatory pathways for identified conditions including chest pain. The department had standard operating procedures.

We observed long waits for ambulance to handover patients in the department. We spoke with crew members and the operational commander. They told us that long waits were inevitable, however they felt this was a system wide issue. To help manage flow an operational manager or a hospital ambulance liaison officer (HALO) were onsite daily.

The number of patients leaving the service before being seen for treatments was low.

Managers and staff started planning each patient's discharge as early as possible.

Staff supported patients when they were referred or transferred between services. The department had a dedicated transfer team which operated from 4pm to midnight. The team consisted of a nurse and a support worker. They specifically transferred patients out of the department to other wards

Managers monitored patient transfers and followed national standards.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas. There were posters in the department to direct patients to the complaint process.

Staff understood the policy on complaints and knew how to handle them. Staff told us they could manage some feedback in the department before it escalated to a formal complaint.

Managers investigated complaints and identified themes. Managers told us about incident themes and actions they had taken to make improvements.

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

Managers shared feedback from complaints with staff and learning was used to improve the service. There were regular staff bulletins which included information about complaints themes.

Staff could give examples of how they used patient feedback to improve daily practice.

Urgent and emergency services

Is the service well-led?

Requires Improvement ↑

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

Leadership

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

The emergency department was part of the Acute and Emergency Medicine Care Group which encompassed the specialties of Acute Medicine and Emergency Medicine.

Leaders in the department understood the daily priorities and issues that the service faced and managed those immediate risks in a dynamic way. They knew about and acted on plans to appropriately escalate pressures the department faced when it was in surge. Senior staff were available to support staff and three hourly safety huddles had been introduced to provide regular visibility of staff in charge of the department and ensure teams could escalate concerns and or risks in a timely way.

The acute and emergency care group triumvirates met with senior leaders fortnightly to review operational oversight of risk, issues and performance.

Leaders and senior leaders within the service were passionate about the department. Staff told us that they were highly visible, and they acted to support the department and the staff.

The service was working to address sustainability amongst the consultants' staffing numbers and had increased the number of WTE (Whole Time Equivalent) consultants. Managers told us that they had plans to deliver consistent named senior cover to each part of the emergency department.

The emergency department provided an Emergency Medicine Consultant to be the team leader for all trauma calls 24/7. This was alongside their clinical roles within the emergency department whilst working a clinical shift. The Trust's Major Trauma service also provided a Major Trauma Consultant between 8-18, Monday to Friday. Part of their role was to assist with trauma calls during these hours. There was a Major Trauma Clinical Lead who had clinical oversight and responsibility for this Trust based service.

The department had a development programme and had secured fifteen places on the compassionate leadership programme for senior leaders to complete.

Vision and Strategy

The service did not have an up-to-date vision for what it wanted to achieve. There was a strategy to turn it into action, developed with all relevant stakeholders, although this was overdue for review at the time of our inspection. The vision and strategy had been reframed to focus on making improvements to quality and safety following our inspection.

Urgent and emergency services

We requested the current vision and strategy documents and the trust submitted separate strategies for each division. Included was a three-year strategy for the acute and emergency care group which was dated 2017-2020. The strategy was out of date therefore it did not reflect the challenges the service faced, and had been facing in recent years, or actions the service planned to take to make improvements to the service.

The trust did submit 'New Trust Corporate Strategy- Making a difference- the next chapter 22-27'. This included the vision of the service but was not specific to the department or care group.

The trust had a Mental health strategy 2022-2025 which set out the vision and key strategic objectives for the care of patients with mental health needs. The strategy was focussed on three key ambitions which were quality care and support, safe and well governed and collaboration and partnership, however there were no specific actions identified for the department or care group. On average 320 patients presenting to the emergency department per month with a mental health presentation and this was identified in the background information, however the strategy did not reflect this nor did it address the identified risk of 16-18-year-olds who presented at the department.

Culture

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

Staff we spoke with felt valued and appeared happy and enthusiastic.

They spoke positively about working in the department. We spoke with 10 staff who felt the culture in the department had improved since the last inspection and was now more open.

Staff felt listened to by the senior leadership team and had regular meetings to facilitate discussion and raise any issues. Staff who had previously felt isolated now felt much more included within the team.

The trust had an Equality, Diversity and Inclusion strategy which aimed to ensure leaders were visible and led by example. The trust was focussed on embedding a zero-tolerance approach to any form of discrimination.

Staff survey results were shared as they were received into the division and individual areas had the opportunity to review and discuss their specialty results. An emergency department staff survey action plan has been developed focuses on the seven people promise themes capturing actions in relation areas where development is needed and specifically to our lowest scoring themes. We saw evidence that they were working to improve staff experience overall.

The emergency department worked closely with occupational health, organisational development, and the freedom to speak up guardian to ensure staff had opportunities to share feedback and were signposted to appropriate support where necessary.

The department had a CQC improvement board in the staff room with a QR Code for staff to give feedback.

Staff in leadership positions spoke highly and with pride about their teams working in the emergency department

Urgent and emergency services

Governance

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

Senior local leaders and senior staff had clear roles and responsibilities for managing risk and incidents outlined in the care group governance framework.

Senior local leaders we spoke with told us that they dynamically assessed risks on a daily basis in the department, which we saw during the inspection.

We reviewed the minutes from the emergency department clinical governance meetings from May, June and July 2022. The action log did not include target dates for actions to be completed, and where actions had documented outcomes, it was not always clear if the action was closed, or further action was required. Actions were not always measurable and did not identify interim actions to improve compliance.

We found examples on inspection where processes were not undertaken in line with trust and national guidance which had been highlighted as concerns at the last inspection. We identified ongoing issues with restraint training, the use of restrictive practices and data security. We were not assured that leaders had addressed all the key concerns highlighted at the last inspection or had sufficient oversight of their progress to date.

The emergency department had employed a governance coordinator role. Weekly governance meetings were held in the department.

Management of risk, issues and performance

Leaders and teams had systems to manage performance. They did not always identify relevant risks and issues. Actions were identified in some instances to reduce the impact of risks, however these were not always reviewed in a timely manner. They had plans to cope with unexpected events.

The emergency department had a risk register which included control measures in place. We spoke to senior leaders, and they told us about their top risks on the register and the strategies they were taking to address the concerns. We reviewed the risk register and not all the risks that they told us about were included on the register. We were not assured that all key areas that were identified at the last inspection were addressed. Therefore, we were not assured that the governance processes that were in place supported local leaders to identify and manage risks and issues in the department.

The training provided to security staff did not meet the standards of the Restraint Reduction Network. This had been raised with the trust as part of the previous inspection, and we were not assured that the trust had taken sufficient action to address these concerns. These concerns had been entered onto the trust's risk register, we noted that these had been listed as actioned and closed.

The trust had a major incident mass casualty plan, however it was now past it due date for review.

There were regular meetings in place to review risks and they were monitored by appropriate staff roles.

The department had information boards which displayed monthly governance and risk information updates. The information boards included top three risks which were falls, pressure damage and nutrition and hydration.

Patients with mental health conditions who were considered at risk were allocated to bays in the clinical decisions unit (CDU). The trust had a standard operating procedure in place which guided staff to remove all items of potential harm and ligature risks. Staff also used a daily mental health risk assessment (DMHRA) and patients assessed as high risk would be allocated one to one observation.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Staff used e-whiteboards and electronic ambulance systems to monitor real time performance. The e-whiteboard gave senior staff in the department real time information about waiting times, numbers of patients in the department, waiting for admission, waiting for triage and waiting to see a doctor. It also automatically calculated the escalation score in the department, based on the indicators set, which made it easy for senior staff to identify which escalation action card they needed to follow.

Reception staff scanned patient letters and documentation directly into the patient record system. This included patients admitted by ambulance where clinical test results, DNACPR records and handover sheets were scanned into the system so that staff had access to important information to make clinical decisions. However, staff we spoke with told us that scanned documented were added to the same section of the record and it was difficult to identify each document.

There was an electronic operational performance dashboard which highlighted trends in performance. Staff used this information to inform ideas and interventions to make improvements to patient care.

Patient information leaflets were available online to patients and there were posters in the department with a QR code which gave access directly to common leaflets and also to the whole database to patients, so they could look at the leaflets outside of the department without needing paper.

Engagement

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

The department took part in an event to engage with twelve young people who had diagnosis of autism, attention deficit hyperactivity disorder (ADHD) and mental health. All but one had attended the ED in mental health crisis or self-harm. This was part of the department's response to the CQC action plan to gather the views, experience and feedback of young people who had used the service and to improve the experience of young people attending ED.

Staff were engaged through the emergency care staff survey where issues were reported, and a subsequent action plan was created to improve staff experience through the People Promise. We saw completed examples of these action plans and found them to include outcomes, measures, timescales and allocated to senior staff to oversee.

The department also received thank you cards and messages which staff were informed about when it was a personal compliment.

Urgent and emergency services

Learning, continuous improvement and innovation

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

The trust had an action plan to monitor the progress of area of concern identified at the last inspection. This included ten areas of focus which was monitored and audited weekly and monthly. Reports were shared with the trust executive group, quality committee and the board of directors. The report provided an update on each outcome, summary of performance against outcome metrics with baseline data and an overview of findings for each outcome.

Medical care (including older people's care)

Requires Improvement ● ➔ 🡐

Is the service safe?

Requires Improvement ● ➔ 🡐

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

Mandatory Training

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

Nursing and Medical staff received and kept up-to-date with their mandatory training. All specialities within the medicine division had exceeded the trust's target of 90% compliance.

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

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. All clinical staff told us that they were given opportunities to complete mandatory training and were able to claim back any time used outside of work.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers were alerted if staff were approaching renewal dates for their training, we saw managers using a red, amber, green (RAG) system to maintain oversight of staff training records.

Safeguarding

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

Nursing and medical staff received training specific for their role on how to recognise and report abuse. The trust had up to date safeguarding policies for adults and children. Staff had access to safeguarding advice and support from link nurses on the ward, from the trust's intranet, ward managers and the trust's central safeguarding team. We reviewed the trust's training statistics in relation to safeguarding, which demonstrated that staff were above the trust target of 90% for both Level 1 and Level 2 modules.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Safeguarding was a standard agenda item we observed being discussed at handovers and safety huddles.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we spoke could describe how to complete a safeguarding referral. They were also aware of who the safeguarding lead was and how to contact them. Staff told us they would always escalate safeguarding concerns to the ward manager.

Staff demonstrated awareness and understanding of safeguarding Staff knew how to make a safeguarding referral and who to inform if they had concerns. The trust had a lead for safeguarding and they (or their delegate) represented the trust at the local safeguarding boards for adults and children. Trust wide level monitoring took place through the safeguarding team who reported at least annually to the board of directors.

Children were not currently permitted to visit on the wards except in exceptional circumstances, but staff could articulate safe procedures if children were visiting the ward.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained. We observed throughout the service that there were fabric curtains placed in situ in clinical areas. There was no evidence of when these had been installed or due for replacement. This was not in line with best practice, due to the permeable nature of the fabric.

The service generally performed well for cleanliness. In line with national guidance from NHSE/I Estates PLACE was suspended for the last two years due to the COVID-19 pandemic, and therefore no results for 2020/21 were available. The trust had plans to recommence with PLACE submissions later in the year. We did see local ward cleanliness audits that had been completed and all wards were consistently above the trust target of 95%.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). There were adequate supplies of hand gel and PPE in all areas, however not all staff were compliant with the bare-below-elbow requirement. We observed staff wearing long sleeved shirts and watches whilst in clinical areas. In addition, we observed fabric curtains in place throughout the service. There was no information available as to when these had been installed, or when they were due to be replaced. Due to their permeable nature, these posed a risk to patients in relation to infection control.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw a number of examples where domestic staff and nursing staff had cleaned equipment and clinical areas. Cleaning staff were able to articulate the differing cleaning solutions used in line with guidance.

There were designated isolation side rooms for patients with COVID-19 symptoms or who were known to be COVID-19 positive. Staff knew which side rooms were designated for these patients and were able to describe how they would provide care to patients with symptoms or newly diagnosed with COVID-19 in accordance with trust policy.

Wards we visited reported low or no cases of clostridium difficile (C. diff) and methicillin resistant staphylococcus aureus (MRSA). Staff described how they worked with the trust's infection prevention control team on a programme of quality improvement at ward level. We reviewed the trusts hand hygiene audit results for the previous 12 months which demonstrated good compliance rates on individual wards for hand hygiene compliance.

Environment and equipment

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

Patients could reach call bells and staff responded quickly when called.We saw during inspection that staff responded quickly when patients requested assistance.

The design of the environment followed national guidance.

Staff carried out daily safety checks of specialist equipment. All equipment was subject to routine planned preventative maintenance as defined by the equipment manufacturer and we saw that equipment had been maintained and safety checked. The trust had systems in place for recording the service and maintenance of equipment, identified through compliance stickers. Managers assured us repairs were made promptly if a piece of equipment developed a fault. Medical devices we looked at were mostly labelled to indicate when they were last serviced or checked for electrical safety, and to identify next test dates. There were two examples of equipment being outside of its service date. These were escalated and addressed at the time of inspection.

Sharps bins were properly assembled, stored off the floor, not over full and signed and dated. Oxygen cylinders were stored in line with national guidance. Fire exits were clear and unobstructed. The resuscitation trolleys were situated on each ward and were all stocked correctly. We reviewed all check lists completed by staff and saw no omissions or errors.

The service had suitable facilities to meet the needs of patients' families. Wards we visited had boards to display public information about the staff on the ward, visiting times, who was in charge, and other useful information, such as mandatory training compliance. There were additional areas such as day rooms and/or activity rooms that could be accessed by patients and families during their admission, however we did not observe these areas in use during our inspection.

Staff on most wards told us that they had enough equipment to support them to safely care for patients, for example for use when moving and handling or caring for bariatric patients. This included pressure-relieving aids. Staff in endoscopy received training for specialist equipment from the manufacturers who came into the hospital when necessary. The endoscopy unit had Joint Advisory Group (JAG) accreditation. JAG accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the criteria set out in the JAG standards.

Staff disposed of clinical waste safely. We saw all clinical waste sharps bins were used and stored in accordance with national guidance.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients (NEWS2). This helped staff to identify and escalate deterioration in a patient's condition. The NEWS2 alert system was used in practice with individual electronic ward boards providing oversight of the clinical area, however this was not yet fully embedded. A trust wide audit had been completed in relation to the escalation of Deteriorating Patients. The period of time reviewed was between the 4th -10th April 22. Data collection took place May 23rd – June 23rd. Results showed 53 patients were identified as having a NEWS2 score of 7+ during the time period audited, and 37 sets of notes were identified and included in the analysis. Only 30% (11/37) of observations had been completed at the correct frequency. Overall, only two sets of notes had a 'Deteriorating Patient Sheet' filed and neither were fully completed. The audit identified further areas of concern, specifically that there was a lack of documented evidence that:

- Observations are measured at the correct frequency based upon NEWS2 score
- Use of the Deteriorating Patient Sheet

- All patients are reviewed by a medic following escalation
- All patients are reviewed within timescales
- All patients not reviewed within timescales are escalated to the Duty Matron

The trust implemented the following ongoing actions to address the concerns identified as a result of the trust wide audit;

- Introduction of the deteriorating patient bleep holder on all inpatient wards (June 22)
- Introduction of the e-whiteboard alert for escalation of patient deterioration (June 22)
- Audit compliance with deteriorating patient bleep holder on all inpatient wards (Jul-Sept 22)
- Audit use of the e-whiteboard alert for escalation of patient deterioration (Jul-Sept 22)
- Identify areas for further training (Jul-Sept 22)

During our inspection, we observed that the trust had made progress in the implementation of these actions. In all of the records reviewed NEWS charts we reviewed were completed correctly, and there was clear evidence of escalation with deteriorating patients.

Staff knew about and dealt with any specific risk issues. We noted improvements to patient risk assessments, which were now completed on admission where appropriate and now included information relating to falls, nutrition and hydration, pressure area care, dementia and moving and handling. We saw evidence that these risk assessments were used to plan individualised care for each patient and relevant pathways were initiated when required. There was evidence that risk mitigations had taken place post-assessment. For example, the service had cohorted bays with a staff member present the full time to respond to patient needs.

The service had a policy and protocol in place to ensure that patients were regularly screened for sepsis. Sepsis training for staff is embedded within the job specific essential training, which covers modules such as patient deterioration, escalation, sepsis and acute kidney injury. We reviewed the trusts training compliance figures for sepsis training which evidenced training compliance within the division of 89% and 96% for medical and nursing staff retrospectively against a target rate of 90%.

The trust incorporated sepsis screening as part of their Escalation of Deteriorating Patients Audit, in line with the National Institute for Health and Care Excellence (NICE). The audit focused on reviewing all deteriorating patients and did not include specific areas reviewing compliance against sepsis policies or protocols.

Guidance for sepsis stipulates that patients presenting with one or more high risk criteria should receive antibiotics within an hour of it being identified. The Escalation of Deteriorating Patients audit did not include details as to how the trust were assured they had administered antibiotics in line with national guidance.

The trust provided copies of the sepsis workplan for 2022/23, which outlined plans to develop their sepsis dashboards to give wards data which would help them measure their response to deteriorating patients, enabling them to test change ideas in their areas, and continuously improve responses to Sepsis. There were no associated timescales attached to this workplan to outline when the changes to the dashboard would be implemented, and the trust did not provide any examples of compliance data generated through this dashboard. We were not assured as to how the trust maintained oversight of the treatment of patients with identified sepsis.

Medical care (including older people's care)

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. Staff could make referral requests on the IT platform or paper and also had the option to request over the telephone. Staff told us that the links with the mental health team were very good and that they could rely on a prompt response if they were worried about a patient.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. We observed staff undertaking daily mental health risk assessments for patients where required.

We observed across all wards inspected that violence and aggression from patients had been listed as one of the top three risks. Staff told us that whilst they were able to use their training in de-escalation, there were instances where restrictive interventions such as restraint and rapid tranquilisation were used. We reviewed two sets of patient notes where rapid tranquilisation had been administered and observed that there had been no recording of patients' physical health observations post administration. This was not in line with the trusts policy for rapid tranquilisation which states that "Patient is reassessed at regular intervals or when their health needs change in accordance with local policy. The patient's vital signs should be diligently monitored in accordance with the Trust Guidelines on Rapid Tranquilisation." This had been raised with the trust as an area of concerns in previous inspections, and we were not assured that the trust had taken sufficient action to ensure that the administration of rapid tranquilisation was completed in a safe manner.

We reviewed instances of the use of restrictive interventions from the 1st May to the 1st of September 2022 which showed there were 118 restrictive practice incidents logged on Datix trustwide.

The service relied on security staff to assist in high-risk incidents where patients were highly aggressive or displayed violent behaviour. Staff did not have or were not aware of guidance for when to call for security staff to assist in managing an incident and security staff did not have clear guidance for how to prioritise responses to staff requests for assistance.

Security staff were required to provide one to one observations of patients presenting with high risks of violence, aggression or absconding. In incidents reports we saw security staff were required to restrain patients. However, security staff had not had the training required to manage restraint safely in a healthcare setting. The training provided to security staff did not meet the standards of the Restraint Reduction Network. This had been raised with the trust as part of the previous inspection, and we were not assured that the trust had taken sufficient action to address these concerns. These concerns had been entered onto the trust's risk register, we noted that these had been listed as actioned and closed.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. We reviewed the hand over sheets on all wards we inspected. We observed that key risks were discussed, and information disseminated to reduce risks. We observed handovers across all wards and observed that all used Situation, Background, Assessment and Recommendation (SBAR). Staff told us that individual wards instigated safety huddles as part of the daily handover process where patient risks were discussed including: staffing, number of patients, risk of falls, enhanced care patients, high NEWS, end of life, cannula care, pressure ulcers, infections, infection control and COVID 19 swab status and do not attempt cardiopulmonary resuscitation orders. For medical outliers, staff could track medical outliers using the trust's electronic patient record system. Staff told us outliers were seen daily by a doctor for the speciality concerned.

Medical care (including older people's care)

Staffing

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

The trust had a Nursing and Midwifery Staffing Escalation Policy, which clearly outlined processes for addressing any shortfalls in staffing and how this should be escalated via senior nurses and midwives on duty or via relevant on-call teams is clearly defined. In addition, the trust had agreed metrics that would identify wards requiring potential further support and/or review – this included if wards had Care Hours per Patient Day (CHPPD) below 85%. A trigger in either one or a combination of these criteria identified in one month would require a Nurse Director (ND) to undertake a professional judgment review within the clinical area and ensure any identified issues are actioned locally, as part of the "How Healthy is Your Ward" process.

Nurse staffing

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

The service had enough nursing and support staff to keep patients safe. We found planned and actual staffing levels were displayed on the entrance to all medical wards we visited. To try and ensure staffing remained safe, both during the day and night, staff used professional judgement, together with an electronic rostering system. A matron of the day was available for any escalation and followed a clear policy of escalation for any unplanned deviations in staffing levels. We were told that following the previous inspection there had been a significant recruitment of overseas nursing staff which had a positive impact.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Senior leaders told us they used the electronic rostering system when redeploying clinical staff to other wards to assess skill and competency. Discussions with ward managers/matrons/bleep holders and risk assessments were completed, based on ward requirements and the staff competency and skill set. Leaders looked across the whole division and moved staff across site when needed based on skills available. The ward manager could adjust staffing levels daily according to the needs of patients.

The number of nurses and healthcare assistants matched the planned numbers. An electronic staffing software was used to support the deployment of staff on a daily basis to keep wards safe and mitigate or reduce risks. The system was able to take into account acuity and dependency of patients and available staff. The electronic system is a daily staffing software matching nursing staffing levels to patient acuity, in real time, allowing informed decision making on staffing levels across the hospital. It enabled visibility and tracking of staff attendance, recording of red flags and professional judgement. Staffing shortfalls were reported and escalated through the central nursing team and could also be reported using the electronic system.

Divisional morning 'huddles' were chaired by the matron of the day. Huddles were attended by the ward shift leads to highlight concerns they may have had in relation to dependency, acuity and staffing levels. This enabled an early response and support to be planned by the divisional senior nursing team. Matrons ensured acuity and dependency levels had been updated on the system and added mitigation, their professional judgement, and changed the risk/colour appropriately to reflect the staffing risk level following the actions taken. Electronic staffing data was reviewed at the trust wide safe staffing meeting where deployment of staff and mutual aid across divisions was agreed.

Medical care (including older people's care)

The service had low vacancy and turnover rates.

In addition, the service had reducing sickness rates. At the time of the inspection, the medical division had a reported total sickness rate of 3.73% for the 6 month period from March to August 2022.

The service had low rates of bank and agency nurses used on the wards.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers told us that permanent ward staff usually took any available additional shifts which was preferred as it maintained continuity of care for the patients.

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

Medical staffing

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

The service had enough medical staff to keep patients safe. Consultants carried out board rounds every day, which included a discussion of each patient with junior doctors. Patients' own specialty doctor would review them twice a week.

The medical staff matched the planned number. All the services we visited had a daily consultant attended board round and multi-disciplinary team meetings (MDTs). All specialities we visited had medicine consultant cover at least two days a week with on call 24hour for weekends and out of hours. Staff outlined established processed to cover short notice gaps (e.g. sickness) to ensure suitable medical cover was established in a timely manner.

The service always had a consultant on call during evenings and weekends. At weekends, there was an on-call rota, and access to consultants present onsite, though not present on every ward.

The Trust had an action card outlining the process to follow. Out of hours gaps had been Identified as an area of high risk therefore additional doctors had been rostered overnight to mitigate the impact of uncovered out of hours gaps.

The service had low vacancy, sickness and turnover rates for medical staff.

The service had reducing rates of bank and locum staff. In the instance of any identified short term gaps – the trust had an established process of identified in the first instance an internal locum, and if this was not successful the trust would seek to appoint an agency locum.

Managers could access locums when they needed additional medical staff, and they had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. To support the medicine wards there were a range of junior doctors who reported good supervision, good learning, and good support from nursing staff. The trust also made use of physician associate roles.

Medical care (including older people's care)

Records

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

Staff used an electronic patient record supported by supplementary nursing paper records for each patient. Patient notes were comprehensive, and all staff could access them easily. We reviewed 26 full sets of patient notes and sections of patients records when looking at examples of care we had observed across the medical wards inspected. In the records we looked at we found that allergies were recorded, medications were reconciled, and assessments, whether for fluids or food, weight, early warning scores, or falls or pressure ulcer care plans, were completed where necessary.

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

Records were stored securely. At our last inspection we said the trust must ensure confidential records are stored securely in line with national guidance. At this inspection on wards we visited notes trollies were mostly left unlocked and unattended with patient notes stored underneath trollies, easily accessible to visitors. This was in breach of trust policy and General Data Protection Regulation (GDPR). Individual patient paper records were stored in folders outside of each bay, or in folders not stored securely in the bay

We noted that version-controlled documents were reviewed in line with trust policy and national guidance. Electronic whiteboards were used on all wards we visited, these recorded key information about patient risks and treatment including flags for patients living with dementia, learning disabilities, patient acuity and discharge plans. The boards ensured that staff had easy access to key information, such as reviews by other members of the multi-disciplinary team and clinical observations.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Electronic prescriptions reviewed on inspection all had allergy status records completed. We found oxygen being prescribed appropriately, where it was being administered to patients. We checked the storage of medicines, fluids and gases on the wards we visited. We found that medicines, fluids and gases were stored securely in appropriately locked rooms or fridges. Checks were in place and stocks seen were in date. We found controlled drugs were locked away in a metal cupboard in a locked room. We carried out a random check of controlled drugs and found all records of controlled drugs that staff kept were complete with no gaps. Stock seen was in date.

We reviewed the use of rapid tranquilisation medicines and found this was not subject to any overarching medicine audit. In records we reviewed, where rapid tranquilisation medication was used, we found staff were not recording use in accordance with trust policy. For example, after administration, staff were not recording patient observations hourly. We raised this with staff at the time of our inspection.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Wards we visited did benefit from a visit by a pharmacy technician each day and during core hours take home medications were being clinically checked and dispensed and patient medication reconciled. We found that staff benefited from 24-hour pharmacy availability.

Staff completed medicines records accurately and kept them up-to-date. Electronic prescriptions reviewed on inspection all had administration records completed.

Staff stored and managed all medicines and prescribing documents safely. Medicines requiring specific secure storage were managed appropriately and records of their administration maintained. Emergency medicines were stored on resuscitation trolleys in accessible areas with regular checks on content and expiry dates an all wards inspected.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services. Pharmacy technicians and pharmacists told us they provided the medicine reconciliation service for patients. Pharmacist additionally, completing targeted reconciliation of specific patients. Errors relating to medicines reconciliation are reported via the trust incident system and investigated and followed up with the pharmacy staff involved.

Staff learned from safety alerts and incidents to improve practice. Safety alerts would be discussed during safety huddles to ensure all staff were aware of them. We were also told that safety alerts were sent by email to all staff.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Incidents

The service managed patient safety incidents. Staff recognised and reported incidents and near misses but did not always do this in a timely manner. Managers investigated incidents and shared lessons learned with the whole team and the wider service once complete. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff were aware of the importance of incident reporting and how to report an incident using the electronic reporting system. Staff we spoke with told us they felt incidents were dealt with appropriately and that learning was taken from them.

Staff raised concerns and reported incidents and near misses in line with trust policy. Ward leaders could give some examples of recent incidents that had resulted in shared learning for the ward. Feedback and learning from incidents were cascaded to staff both individually and via team meetings. Staff could request to receive feedback via an email linked to the electronic reporting system.

The service had no never events on any wards.

Staff did not always report serious incidents clearly and in line with trust policy. We reviewed NRLS between October 2021 and August 2022 and found that incident report times were variable and not always timely. Out of 24990, incidents there were 917 reported 90+ days after the incident occurred. 196 of these had been graded as moderate and above. This meant that investigations, lessons learned and actions put in place to prevent reoccurrence were not timely.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. Ward managers and most of the staff we spoke to knew of the Duty of Candour requirements. They understood that this involved being open and honest with patients and had been involved in investigations and responding to patients and families

Medical care (including older people's care)

Staff received feedback from investigation of incidents, both internal and external to the service although this was not always timely. Incident learning was shared on individual ward boards for openness and transparency. Staff told us that they would receive initial feedback from reporting an incident and further feedback would be provided once the incident had been investigated.

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

There was evidence that changes had been made as a result of feedback.

Managers investigated incidents thoroughly, but investigations were not always completed in a timely manner due to delays in reporting. Patients and their families were involved in these investigations. We reviewed five incident reports supplied by the trust, each of which demonstrated that Duty of Candour had been applied, where relevant families had been involved throughout the investigation process, evidence of a corresponding acting plan and identified learning to be applied as a result of the investigation.

Managers debriefed and supported staff after any serious incidents.

Is the service effective?

Requires Improvement ● ➔🡐

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

Evidence-based care and treatment

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

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

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. The trust had systems and processes in place to ensure that care was given by the service according to published national guidance such as that issued by National Institute for Health and Care Excellence (NICE). All staff we spoke with could access, via the trust's intranet, guidelines, policies, and procedures relevant to their role.

Clinical policies had been developed based on national guidance such as the National Institute for Health and Care Excellence (NICE). We found care was provided based on best possible evidence and in line with national guidance.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Teams had access to a psychiatric liaison team on site.

Staff undertook a daily assessment of patients mental health. We saw that this was a fixed point in the newly introduced safety huddles.

Medical care (including older people's care)

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. We observed prior to mealtimes, staff undertook a huddle to discuss patients with any specific dietary requirements and identify patients who may require assistance with their meals. We saw snack and drinks trolleys on wards that were accessible to patients. All patients had individual access to their own water jugs and cups within their bays or side room.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Patient care records had no omissions or errors in diet and fluid records.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it and patients requiring this were frequently reviewed. Where modified diets or fluid were required, assessments of a patient's requirements were detailed above their beds. There were issues around patients receiving specialist support from speech and language therapists over the weekend, but staff were able to describe the mitigation in place.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.All staff we spoke with knew about pain assessments and how to score patients level of pain. We saw in all patient records that we reviewed that pain scores were accurately recorded.

Patients received pain relief soon after requesting it. Patients we spoke with told us staff managed their pain in a timely way.

Staff prescribed, administered and recorded pain relief accurately. Pain relief was prescribed, and staff would request additional pain relief from medical staff, if required. We requested any completed pain audits, but none were provided.

Patient outcomes

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

The service participated in relevant national clinical audits. Managers and staff used the results to monitor and improve care and treatment. We saw audit information displayed in ward areas and ward managers discussed results with staff.

Outcomes for patients were not always positive, consistent and did not always meet expectations, such as national standards.The trust provided a range of supporting action plans following their clinical audit programme, which identified areas in which the trust was not in line with national standards. Action plans were also provided which contained high level summaries on how the trust would develop their services to better meet the needs of patients.

Medical care (including older people's care)

Trust performance in relation to thrombolysis was not in line with national standards of 20 % of all patients receiving treatment and less than 40 minutes median time between clock start and thrombolysis. Audit results highlighted that only 9.7% of patients are given thrombolysis, and there was a 54-minute median time between clock start and thrombolysis. Whilst this was an improvement on the 2019/20 position and the trust had not been identified as an outlier, we were not assured the trust was moving at pace to improve their position.

We reviewed the trusts National Lung Cancer Audit (NLCA) 2018 data (published 2020) and 2019-2020 data (published 2022), and the associated action plans. In the 2020 Report (2018 data) the trust results had continued to remain below the national average for two key performance indicators;

1. Pathological diagnosis (%) – Trust performance was 63.8% against the 69.4% national average. This resulted in 36.2% of patients not receiving a pathological diagnosis.
2. Anticancer treatment (%) – Trust performance was 54.3% against the 58.5% national average. This resulted in 45.7% of patients not receiving anticancer treatment

In the 2022 Report (2019 and 2020 data) it wasn't possible to produce trust level data, and therefore national and alliance-level data was published. This meant that the trust were unable to risk assess the 2019 and 2020 results for the NLCA audit.

We reviewed the trusts National COPD Secondary Care Audit September 2019 - February 2020 and the associated action plan. The trust had made significant improvements compared to the 2018/19 results that had indicated 33% of patients who required oxygen had not had this prescribed. The 2019/20 data highlighted that 100% of patients who required oxygen had this prescribed. However, the trust had failed to take action to address non-compliance against the following key performance indicators;

66% of patients requiring non intensive ventilation did not receive it within 2 hours of arrival.

- A spirometry result is not available for a patient admitted to hospital with an acute exacerbation of COPD. A spirometry result was not available for 35% of patients.
- 70% of smokers were not referred to behavioural change intervention and/or prescribed a stop smoking drug, however 100% of smokers were offered this intervention.
- A patient does not receive a respiratory review within 24 hours of admission. 6% of patients did not receive a respiratory review within 24 hours of admission.
- A patient does not receive a discharge bundle to support the discharge process and ongoing management of their COPD. 8% of patients did not receive a discharge bundle.

Managers and staff used the results to improve patients' outcomes and care and treatment. We saw that the increasing trend in patient falls had been identified but noted a significant reduction following the introduction of falls avoidance information given to all patients on admission and regular discussion of falls as part of the newly implemented safety huddle. Wards had developed signage to indicate the number of days since the last patient fall and staff commented that having visual aids reflecting performance had encouraged staff to sustain improvements.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Staff and senior leaders outlined the usage of their electronic system, which allowed staff to complete relevant clinical audits. We saw that the service had a comprehensive audit programme.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time.

Managers shared and made sure staff understood information from the audits. We saw examples of how audit results had been shared with staff through email and in safety huddles

Improvement is checked and monitored. We saw that all audit results had planned reviews and specific staff allocated to oversee the ongoing monitoring.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work. The trust provided newly qualified nurses and international nurses were with a preceptorship period.

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

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff we spoke with confirmed that there was a system in place to ensure staff received an annual appraisal. The current compliance rate for appraisals for medical staff was 87% and 85% for nursing and midwifery staff trust wide.

Managers supported nursing and medical staff to develop through regular, constructive clinical supervision of their work. The division was focused on performance appraisal and development reviews (PADR) for junior doctors looking to provide additional supportive measures to increase compliance in training overall.

The clinical educators supported the learning and development needs of staff.

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

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers told us that as part of their appraisals and supervision they would identify training or development needs for their staff and encourage them to pursue additional opportunities to improve.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. All staff told us that managers were keen to assist staff to develop within their roles.

Managers made sure staff received any specialist training for their role. All staff told us that they were given ample opportunities to undertake further training and competencies for their role.

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

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

Medical care (including older people's care)

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We saw there were daily multidisciplinary team (MDT) meetings on each of the wards, attended by a range of nursing and medical staff, clinical support workers, pharmacy staff, occupational therapists and physiotherapists. These meetings included discussions about patients' conditions and needs, clinical care and discharge planning. We observed an MDT meeting and saw that all staff had an input into care and contributions were value

Staff worked across health care disciplines and with other agencies when required to care for patients. Allied health professionals including occupational therapists, physiotherapists and speech and language therapists all provided care as part of each ward team and contributed to patient records. They participated in safety huddles on each ward.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. We observed an example of a referral during inspection, staff told us the psychiatric liaison team were efficient in streaming referrals to ensure patients were seen and reviewed quickly.

Patients had their care pathway reviewed by relevant consultants.

Seven-day services

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

Consultants led daily ward rounds on all wards on weekdays. Patients are reviewed by consultants depending on the care pathway. We reviewed the notes of 26 patients and found they all had a clinical assessment undertaken by a consultant as required within 12 hours of admission. At weekends, there was an on-call rota, and access to consultants present onsite.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Key diagnostic tests (such as scans) could be undertaken seven days a week with urgent cases seen out of hours and at weekends. Medical staff we spoke to told us there was good access to diagnostic services. The service offered seven-day 24-hour discharge and the pharmacy was open seven days a week.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards. Wards we visited had lots of information available for patients on leaflet racks.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Patients are screened on admission for smoking and alcohol intake as part of the admission pathway and offered advice on cessation.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They did not always use measures that limit patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care, however this was not always recorded. We observed during our inspection staff completing a Daily Mental Health Risk

Medical care (including older people's care)

Assessment for patients, which prompted staff to consider patients capacity as a part of this. We noted within patients records that where questions had been raised regarding a patient's capacity, this had been noted – but when considering an application for Deprivation of Liberty Safeguards, staff did not always implement Deprivation of Liberty Safeguards in line with approved documentation. We observed three examples where patients had been subjected to a DOLS order but did not have corresponding capacity assessments and/or a decision recorded in the patients' best interest.

Staff gained consent from patients for their care and treatment in line with legislation and guidance and made sure patients consented to treatment based on all the information available Staff clearly recorded consent in the patients' records.We observed numerous examples throughout all patient notes we reviewed where consent had been sought appropriately to enable safe care and treatment.

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

Nursing and medical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. We reviewed the most recent Mental Capacity Act and DoLS training report, which outlined training compliance was above the trust target of 90% for all Medical specialities.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff we spoke with were able to provide a concise and accurate summary of the key principles relating to this legislation.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. We observed during our inspection staff members in dialogue with the trust's psychiatric liaison team, and staff outlined how they could access further information via the intranet.

Is the service caring?

Good ● ➔ ➔

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed many interactions between staff, patients and others (for example carers and relatives) during our inspection. We found all staff to be polite, respectful, professional and non-judgmental in their approach.

Medical care (including older people's care)

Patients said staff treated them well and with kindness.Staff of all grades introduced themselves to patients, and asked what patients preferred to be called. We observed staff responding to patients' needs in a compassionate and timely manner; the patients we spoke with all had call bells available and those that had asked for assistance said they had not waited long before a member of staff attended. Staff conducted regular comfort rounds to assess patients' needs, such as if they required assistance to the toilet, if they were comfortable and if they would like anything to eat or drink

Staff followed policy to keep patient care and treatment confidential. Patients bed curtains were drawn when providing care and treatment and nursing and medical staff spoke with patients in private to maintain confidentiality.

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

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

Emotional support

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

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

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. We saw that patients were well supported emotionally, and staff were caring and empathetic. There was a room available on the wards we visited for the use of patients and families and for staff to hold discussions with patients if they were distressed.

Staff told us that they had completed training on breaking bad news and demonstrated empathy when having difficult conversations. We requested details of mandatory and role specific training provided to staff, and noted that there was no formal recording of breaking bad news training captured within these records. We were unable to review any documentation that supported staff's comments regarding this training.
Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

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

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

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

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

Staff supported patients to make advanced and informed decisions about their care.

Medical care (including older people's care)

Patients gave positive feedback about the service. We saw multiple examples of positive feedback received on all wards we visited.

Is the service responsive?

Requires Improvement ● ➔🡐

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

Service planning and delivery to meet the needs of the local people

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

Managers planned and organised services so they met the changing needs of the local population.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The trust is required to submit data to national bodies showing how often it has breached the standards which seek to eliminate mixed sex accommodation. This is a requirement for all NHS trusts. The trust had three breaches of the eliminating mixed sex accommodation guidance and all were in January 2022. The trust explained that this was due to a period of exceptional demand due to the impact of the COVID-19 pandemic. The three breaches of the standards were the first breaches occurring in the trust since January 2019.

Facilities and premises were appropriate for the services being delivered.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. Staff told us they had good communication systems in place with the mental health team to ensure timely intervention. We observed staff contacting the team during our inspection and noted a prompt arrival of the mental health team onto the ward.

The service had systems to help care for patients in need of additional support or specialist intervention. Due to staffing shortages, additional one to one care was not always fulfilled on some wards, however staff took action to mitigate against potential risks by cohorting patients. We saw that staff had access to additional specialist equipment such as bariatric hoists and chairs.

The service relieved pressure on other departments when they could treat patients in a day.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

Not all wards were designed to meet the needs of patients living with dementia. We raised this at the time of inspection, and we were told that there was an ongoing programme of work to refurbish the wards and that the refurbishment plans included making the wards meet the needs of patients living with dementia.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. The service had introduced a flag system within the digital platform to enable staff to identify patients with learning disabilities and dementia. We saw several examples of the 'This Is Me' document being used by staff on the wards we visited.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. We observed during inspection that for one patient who required interpreters, staff had co-ordinated for other agencies involved in this patient care to attend the ward whilst the interpreter was present. All staff were able to tell us where they could access these resources.

Patients were given a choice of food and drink to meet their cultural and religious preferences. We observed a meal service during inspection and saw examples of differing food options available.

Staff had access to communication aids to help patients become partners in their care and treatment.

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. However, given the significant strain on capacity in services it was not always possible to do this.

We inspected the pathway of medicine patients from admission in accident and emergency/GP referral to point of discharge. Patients were assessed on admission to determine what treatment pathway was required. There were differing pathway options available within the medicine speciality.

The hospital had significant capacity problems due to the high number of patients who were medically fit for discharge but who did not have a care package immediately available for discharge to be carried out safely. The situation was made worse by the complexities of COVID 19 pathways and keeping some patients isolated. Staff were required to monitor the number of delayed discharges and look at how to manage these effectively. The trust had failed to meet any of the cancer two week wait targets in the previous 12 months. Overall trust referral to treatment times (RTT) were worsening with only 64% compliance in August 2022 compared with 72% in September 2021. We requested specific service and specialty data but this was not available.

Managers and staff worked to make sure patients did not stay longer than they needed to. Senior leaders were aware of

the pressures within the service. Managers and clinical leaders participated in site meetings held regularly throughout the day, every day. During these meetings managers discussed the number of patients waiting for within the service, the number of discharges planned for patients, and how to mitigate the risks presented by capacity and demand. Average length of stay for the medical division was 23 nights on average for the past three months

The service moved patients only when there was a clear medical reason or in their best interest.

Staff tried not to move patients between wards at night because it was recognised as adding stress and anxiety for patients if they were moved. Patients were allocated beds throughout the night with planned moves to take place the following morning. However, staff told us this was not always possible due to the high demand on beds and sometimes patients were moved between wards at night.

Managers monitored that patient moves between wards were kept to a minimum.

Managers and staff started planning each patient's discharge as early as possible. Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. At the time of the inspection, there were a total of 166 patients who were medically optimised and fit for discharge. Patients were waiting for a package of care, a discharge to assess bed in the community or continuing healthcare assessments to progress their discharge. There were many patients waiting for community hospital beds for rehabilitation after an acute illness and these patients had complex needs with most wanting to return to their own home. Due to complexities in assessing patients who needed onward care, and the lack of care packages available to be purchased or arranged by social services, there were delays in discharging patient's home. The staffing shortages in adult social care had a detrimental effect on the whole system of access and flow for medical care. Significant pressures on partner organisations for home care & domiciliary care, resulted in significant delays to discharge.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the highest number and took action to prevent them. A delayed discharge occurs when a patient, clinically ready for discharge, cannot leave hospital because the other necessary care, support or accommodation for them is not readily accessible and/or funding is not available. Barriers to timely discharge included transport delays, completion of an electronic discharge summary, awaiting medication and implementation of care packages. We reviewed figures in relation to delayed discharges for the previous three months there had been 165 delayed discharges on average. This had a negative impact on access and flow.

Staff supported patients when they were referred or transferred between services.

Managers monitored patient transfers and followed national standards.

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

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Medical care (including older people's care)

Patients, relatives and carers knew how to complain or raise concerns. Staff were proactive in asking for feedback. We saw feedback boxes on each ward we visited but signage was inconsistent. We requested from the trust information regarding the number of complaints that had been received over the past 12 months. The medicine division at Northern General Hospital had received 35 complaints.

The service did not clearly display information about how to raise a concern in patient areas. We saw inconsistencies regarding displayed information on making complaints in any patient area that we visited.

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

Managers investigated complaints and identified themes. The division had identified a number of main categories in relation to complaints received about the service which were; general nursing care communication with patients, bedside manner, competence of staff and inappropriate discharge.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff told us that any learning from complaints would be discussed as part of their morning safety huddle, and that staff would also receive feedback on a case-by-case basis if they had been involved in the complaints process.

Managers shared feedback from complaints with staff and learning was used to improve the service. Managers shared with us examples of complaints that they had received and investigations and outcomes that came from them.

Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Requires Improvement ➔🡐

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

Leadership

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

There was a clinical director for each speciality within the division, supported by nursing and operations directors, Deputies and then ward matrons and service managers.

We saw examples of leadership at site level with regard to communication with matrons and ward managers. Specific medical wards had differing leadership from onsite matrons. Staff told us they felt supported by matrons and senior nurses. Leaders we spoke with felt that they were visible. However, staff on the wards did not feel that there was leadership visibility aside from ward managers and matrons at local level.

We spoke with staff in leadership roles and they all described having been trained in leadership or having access to the trust's leadership programme. We saw from minutes of governance meetings we reviewed and from speaking with leaders that leaders understood the priorities and most of the issues the medicine service faced.

Medical care (including older people's care)

Vision and Strategy

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

Senior leaders had an annual workforce plan and were sighted with regard to overall recruitment of staff from nursing, medical and non-clinical staff. The division had highlighted speciality hotspots and the impact this would have on staff. The trust had an action plan in place to work towards in order to rectify individual concerns surrounding differing skill set.

We saw that the trust had various strategies to support it on delivering the strategic aims, including a quality strategy, a people strategy, and at department levels, operational strategies and business plans.

In addition, the trust had launched PROUD behaviours in June 2022 to further aid staff in embodying the trust's vision and values of Patient First, Respect, Ownership, Unity and Delivery. The values had been developed in consultation with staff and triangulated with various data sources such as NHS staff survey results. During the roll out phase, the trust undertook several engagement sessions with staff trust wide to embed the PROUD framework. Leaders have access to an activity pack via the trusts intranet page to facilitate discussions within teams about the behaviours and values at the heart of the framework.

Culture

Staff felt more respected, supported and valued since our previous inspection. They were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had a more open culture where patients, their families and staff felt they now could raise concerns without fear.

Staff told us there was an improved and more open culture. Staff told us that they felt confident to raise concerns with their managers. Staff members that we spoke with expressed their frustrations at the ward moves their team encountered due to short staffing across the division. Staff told us that staff shortages often impacted on the quality of patient care, and that staff felt they were not always able to provide high quality personalised care due to operational pressures.

Whilst staff commented that currently morale within the division was low, staff also spoke proudly of their colleagues and the hard work they encountered during the pandemic. Staff said they felt valued by their peers but felt there was a disconnect between clinical and executive staff.

We reviewed the most recent data and analysis relating to the NHS 2021 Staff survey. Due to the changes in the survey reporting comparisons can only be made to last year for the staff engagement and morale theme scores trust wide. Both scores had experienced a statistically significant decrease. The trust had agreed actions to address concerns relating to morale by generating a heat map of areas with lower morale that had been identified. People promise managers had also been tasked to look at the correlation of morale on retention by holding focus groups and reviewing retention data such as exit interviews surveys and feedback from engagement interviews.

Staff survey results were shared as they were received into the division and individual areas had the opportunity to review and discuss their specialty results. The division reviewed the most recent staff survey and identified the key

areas. The division work closely with human resources, occupational health, organisational development, and the freedom to speak up guardian to ensure staff had opportunities to share feedback and were signposted to appropriate support where necessary.

Staff in leadership positions spoke highly and with pride about their teams working on the wards.

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff at all levels had greater clarity about their roles and accountabilities and had regular opportunities to meet and discuss regarding the performance of the service, learning was not always identified and implemented.

The medicine division had a clear governance framework with staff assigned specific roles that ensured quality performance and risks were known about and managed.

We found a examples on inspection where processes were not undertaken in line with trust and national guidance which had been highlighted as concerns at the previous inspection. We identified ongoing issues in relation to the completion of mental capacity documentation, the use of restrictive interventions and training in relation to this, secureness of patient records, reporting of incidents. Whilst improvements and actions had been implemented, we were not assured that leaders had addressed all the key concerns highlighted at the last inspection or had sufficient oversight of their progress to date. This was reflective of what we found during this inspection. Whilst the division had made improvements in areas such as the management of deteriorating patients, further work was required to embed improvements and actions. In addition, we were not assured that processes to both review existing and identify new potential areas of risk were robust.

The service had a series of reports feeding into key meetings within the division, demonstrating the use of performance information to allow oversight and governance of improvement work such as the use of the Safety, Risk and Quality (SRQ) Dashboard. The reporting process was reviewed and discussed at a number of forums including medicine safety committee, medicine governance and ward managers meetings.

We reviewed the minutes of the divisional clinical governance meetings. Items were aligned to the integrated performance report so that local leaders and the board were aware of the same issues and risks. We noted discussion such as mandatory training, IPC, risk, appraisals, complaints, incidents, and performance were considered at the meetings.

Management of risk, issues and performance

Leaders and teams had systems to manage performance. They did not always identify relevant risks and issues. Actions were identified in some instances to reduce the impact of risks, however these were not always reviewed in a timely manner. They had plans to cope with unexpected events.

The leadership team were aware of their main risks and could explain the actions in place to mitigate their risks. Risks were identified and discussed and escalated for consideration for inclusion onto the risk register via divisional governance meetings.

Medical care (including older people's care)

Risks were clearly described on the divisional risk register with clear actions taken to reduce or manage the risk, but these were not always reviewed in a timely manner. We reviewed copies of the risk register for all medical specialities and noted examples where risks included on the register were overdue for review, such as the Integrated Stroke and Geriatric medicine risk register were we noted the following;

- 21 High level risks - 9 overdue for review
- 24 Moderate level risks - 12 overdue for review
- 29 Low level risks – 19 overdue for review
- 14 risks due for review in the next 8-60 days

The trust had a comprehensive policy and supporting procedure that could be enacted to enable business continuity. Staff had access to flow diagrams that provided a key overview of the business continuity plan.

We saw governance boards on individual wards which displayed monthly governance and risk information updates. The information included individual wards top three incident themes, falls and pressure ulcer statistics, three things that had gone well and learning from incidents. The boards also included messages for sharing, patient feedback, three things individual wards wanted to improve upon, staff achievements, mandatory training and staff appraisal compliance data. Individual wards also displayed weekly team huddle information. The information included highlights surrounding star of the week, wellbeing at work, team messages, what's new, hot topics, achievements and performance.

Information Management

The service collected reliable data and analysed it, however this was not always available at location level. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff were aware of their responsibilities in relation to data protection and making sure that confidential information was managed securely through annual information governance training, however we found patient information was not always secured appropriately on the wards. For example, notes trollies were left unlocked on all the wards we visited. In addition, data supplied post inspection by the trust was not consistently separated by location level and had been aggregated to give a trust wide view of the medicine division. It was unclear as to how the trust were able to identify any differentiations in performance at site level, and use this to drive performance at location level.

Staff could access information technology (IT) systems to record and view information such as test and x-ray results and patient records. Patient records were electronic, and many assessments were integrated into the trust's electronic patient record system. Staff we spoke with demonstrated they could locate and access relevant information and records to enable them to carry out their day-to-day roles.

Ward managers could access information on the electronic staff record which helped them manage their teams. This included information on staffing, staff sickness, mandatory training, and appraisals. The service managed and used information appropriately to support its activities. The website contained detailed information about the differing wards, site maps, innovation and how to book an appointment.

The trust submitted all data and notifications to external organisations but did not always do this in a timely manner.

Medical care (including older people's care)

We reviewed NRLS between October 2021 and August 2022 and found that incident report times were variable and not always timely. Out of 24990, incidents there were 917 reported 90+ days after the incident occurred. 196 of these had been graded as moderate and above. This meant that investigations, lessons learned and actions put in place to prevent reoccurrence were not timely.

Engagement

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

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We saw comment boxes and cards located on wards, which allowed visitors to provide direct feedback. The trust participated in the Friends and Family Test (FFT), however since restarting FFT in October 2020, the 95% positive score target has not been achieved by the trust.

The Patient Experience Team are currently reviewing which wards have returned the most cards and what impact, if any, this has had on individual scores and response rates.

Staff engaged through the staff survey where issues were reported, and a subsequent action plan was created to improve staff experience. The 2021 results reflected that this year had seen the lowest response rate for the past 5 years at 38.3%.

Learning, continuous improvement and innovation

Staff displayed commitment to improving services in light of previous inspection findings. The service had understanding of quality improvement methods and articulated a desire to utilise these moving forward.

All staff were committed to continually learning and improving services. Staff and senior leaders articulated various improvements that had been implemented as result of the previous inspection, and acknowledged that there was still further work required to improve services.

The service displayed ward information was displayed outside each ward on a Quality board. This gave key and candid information about the ward's performance, such as patient safety message of the month, improvement initiatives, IPC, risks and learning from incidents, to staff, patients and visitors. Staff received learning specific to their ward on notice boards which captured learning after significant events and safety reminders.

Surgery

Requires Improvement ● → ←

Is the service safe?

Requires Improvement ● ↑

Our rating of safe improved. We rated it as requires improvement.

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. The overall training compliance for surgery was 93% against a trust target of 90%.

The mandatory training was comprehensive and met the needs of patients and staff. All staff spoke positively about the practice developers and how they improved access to training.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. All clinical staff told us that they were given opportunities to complete mandatory training and were able to claim back any time used outside of work.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers were alerted if staff were approaching expiry of existing training, we saw managers using a red, amber, green (RAG) system to maintain oversight of staff's training records.

Safeguarding

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

All staff received training specific for their role on how to recognise and report abuse. Training data provided demonstrated compliance was in excess of the trust target of 90% for most staff groups. Several wards were beneath the trust target, ward H6 training compliance was 65% and F3 was 74% compliance.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Not all staff had direct experience of making a safeguarding referral, but all staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff could identify the safeguarding lead within the organisation.

Children were not currently permitted to visit on the wards except in exceptional circumstances, but staff could articulate safe procedures if children were visiting the ward.

Surgery

Cleanliness, infection control and hygiene

The service still did not consistently control infection risk well. Staff did not consistently use equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

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

In line with national guidance from NHSE/I Estates PLACE environmental audits were suspended for the last two years, and therefore no results for 2020/21 were available. We did see local ward cleanliness audits that had been completed and all wards were consistently above the trust target of 95%.

Staff used records to identify how well the service prevented infections.

Staff worked effectively to prevent, identify and treat surgical site infections. All wards met the trust target of 100% prevention of surgical site infection (Post-operative) and prevention of surgical site infection (Pre-operative) for the 12 months preceding inspection. Surgical site infections were consistently beneath 1% for the last 12 months.

Staff did not always follow infection control principles; we saw multiple examples of staff across all roles and grades and across all surgical wards not correctly wearing personal protective equipment (PPE) in line with the trust's requirements at the time of inspection.

Staff told us that they cleaned equipment after patient contact but there was no consistent use of 'I Am Clean' stickers as per trust policy. We saw the stickers were not being used or when used they had out of date information recorded.

Following inspection, we requested infection prevention and control (IPC) audits, these showed issues with hand hygiene compliance across the directorate, especially on wards C4, F8 and F9 where the target for compliance was not consistently achieved in the reporting period of April 2022 to September 2022. Ward C4 only achieved compliance in one month in the reporting period and F8 and F9 only achieved compliance in two months. This had been recognised as an issue prior to inspection and it featured within the trust's improvement plan.

Environment and equipment

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

Patients could reach call bells and staff responded quickly when called. We saw during inspection that staff responded quickly when patients requested assistance.

Staff carried out daily safety checks of specialist equipment. We saw that daily safety checks were undertaken and recorded. We reviewed records and saw no omissions in the completion of records.

The service had enough suitable equipment to help them to safely care for patients. Staff told us that they had enough equipment to do their job properly. We were also told that any replacements were ordered from the equipment library and were delivered promptly.

The resuscitation trolleys were situated on each ward and were all stocked correctly. We reviewed all check lists completed by staff and saw no omissions or errors.

Surgery

Staff disposed of clinical waste safely. We saw all clinical waste sharps bins were used and stored in accordance with national guidance.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. We saw that the National Early Warning System 2 (NEWS2) system was being used and that there was clear evidence within all patient records that we reviewed that it was being utilised effectively.

At the last inspection there was evidence of patients not being escalated appropriately with the medical review being omitted, at this inspection we saw that they was a designated doctor for all deteriorating patients to ensure that staff knew who to contact and that patients were seen appropriately.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. In all 30 records that we reviewed we saw assessments for the risk of pressure area damage, falls, malnutrition and venous thromboembolism (VTE). We saw evidence of staff using risk assessments when things had changed for a patient and making adjustments based on that information.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). Staff told us that the links with the mental health team were very good and that they could rely on a prompt response if they were worried about a patient.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. We requested the records of any patient with mental health issues and we saw risk assessments had been completed appropriately.

Shift changes and handovers included all necessary key information to keep patients safe. We observed handovers across all wards and observed that all used Situation, Background, Assessment and Recommendation (SBAR).

Since the previous inspection there have been seven never events in theatres which highlighted issues with the completion of surgical safety checklists. At this inspection we observed improved practice and local audits received post inspection demonstrated that there was significant improvement towards 100% compliance.

At the previous inspection we identified concerns regarding the sharing of key information to keep patients safe when handing over their care to others. At this inspection we saw that all wards had introduced safety huddles for the sharing of key information. We observed a number of huddles across different wards and we observed a consistent approach which included the same key areas of information being discussed.

Nurse staffing

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

The service had enough nursing and support staff to keep patients safe. We were told that following the previous inspection there had been a significant recruitment of overseas nursing staff which had a positive impact.

Surgery

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

The ward manager could adjust staffing levels daily according to the needs of patients. Staff were moved between wards according to the acuity of patients and any increased need.

The number of nurses and healthcare assistants matched the planned numbers. We saw minimal differences across all wards in planned staffing numbers versus actual staffing numbers.

The service had a nursing retention rates of 89% in excess of trust target of 85%.

The service had low turnover rates. The trust target was less than 10% and current turnover was 8%.

The service had a gradual increase in sickness rate from 2% to 4% in the last 12 months, but this was still within trust targets.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers told us that permanent ward staff usually took any available additional shifts which was preferred as it maintained continuity of care for the patients.

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

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The Trust was unable to provide detailed vacancy information covering a defined period of time due to the rotational movement of the junior doctor workforce which resulted in vacancies spreading over a number of specialty areas.

Sickness rates for medical staff were 4%.

The medical staff matched the planned number. We spoke with five doctors across the hospital who told us they felt well supported by their senior team members and were able to access advice and peer support as they required it.

Doctors were supported by the ‘hospital at night’ system with three advanced nurse practitioners and two support workers who could help with tasks such as cannulation and taking bloods.

Senior clinicians and consultants we spoke with said there was no shortage of junior doctors on the wards.

We saw on the wards we visited sufficient numbers of medical staff to meet the needs of patients.

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

Records

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, easily available to all staff providing care but were not always kept securely.

Surgery

Patient notes were comprehensive, and all staff could access them easily.

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

Records were not always stored securely. We saw examples of computers being unlocked and left unattended. We also saw unlocked and unattended medical notes trolleys.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. Medicines were not always stored securely.

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

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. We saw pharmacists on the wards speaking with staff and patients. We were told that there was a pharmacist available 24 hours a day for advice.

Staff completed medicines records accurately and kept them up-to-date. We reviewed prescription charts in 30 sets of patients notes and found no errors or omissions.

Staff stored and managed all medicines and prescribing documents safely. We saw that all medicines were stored appropriately and securely.

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

Staff learned from safety alerts and incidents to improve practice. Safety alerts would be discussed during safety huddles to ensure all staff were aware of them. We were also told that safety alerts were sent by email to all staff.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. All staff were aware of the changes to the trust rapid tranquilisation but none of the staff we spoke with had any direct experience of this being required.

At the last inspection there were issues with the storage of oxygen bottles, and during this inspection we still saw oxygen bottles being stored inappropriately. There were examples of unsecured bottles on the wards and within storage areas, and this posed a safety risk to both staff and patients.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. All staff reported a culture of openness with incident reporting. Everyone felt that it was a positive and not punitive process with every member of staff encouraged to report incidents.

Surgery

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. Staff could give multiple examples of incidents that they or colleagues had reported.

The service had no never events on any wards. At the time of inspection there had been seven never events in theatres since the previous inspection which concerned the completion of surgical safety checklists. We saw that work had been undertaken to address these issues and whilst this work was not yet fully embedded, the pace of change was sufficient.

Staff reported serious incidents clearly and in line with trust policy. Staff could articulate what would constitute a serious incident.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We reviewed three responses to incidents and saw that all obligations under duty of candour were met.

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

There was evidence that changes had been made as a result of feedback. At the previous inspection there had been a theme identified through incident reporting of increased patient falls. At this inspection we saw across all wards that falls prevention information and no slip socks were provided to all patients. We also noted that the number of incidents regarding falls had reduced.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us that they would receive initial feedback from reporting and incident and further feedback would be provided once the incident had been investigated. We noted that not all staff were able to give examples of any incidents that had happened on different wards. This was particularly apparent on F2 ward with most junior staff being unable to give examples of incidents that had occurred elsewhere.

We were not assured that all managers shared learning about never events with their staff and across the trust. All theatre staff were aware of the never events but no ward staff knew that they had occurred and no shared learning was apparent.

We were not assured that managers shared learning with their staff about never events that happened elsewhere. No member of staff could give examples of never events that had occurred elsewhere including in the trust's other surgical services.

Is the service effective?

Good ● ↑

Our rating of effective improved. We rated it as good.

Surgery

Evidence-based care and treatment

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

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

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. We reviewed medical records of patients currently subject to the Mental Health Act and saw all documentation completed without omission or error.

At the previous inspection we saw that cognitive assessments for patients with dementia had not been completed. At this inspection we specifically requested records of patients with dementia and we saw completed cognitive assessments in the six records that we reviewed.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We saw that this was a fixed point in the newly introduced safety huddles.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. All patients spoke positively about food choices and quantity of food provided. We saw that any additional dietary or hydration needs were consistently covered in all ward safety huddles and was a fixed point to cover. We also saw the use of a colour coded system to identify varying dietary needs.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. We reviewed 30 sets of patient care records and saw no omissions or errors in the completion of diet and fluid records.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We reviewed 30 sets of patient care records across the directorate and found that all records had a completed malnutrition risk assessment.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. There were issues around patients receiving specialist support from speech and language therapists over the weekend, but staff were able to describe the mitigation in place.

We saw examples of different dietary needs being met. We saw religious, cultural and specialist options as well as such requirements as low salt, low fat or a softened consistency.

Staff told us that patients waiting to have surgery were not left nil by mouth for long periods and that national guidelines were followed. We requested any completed audits to evidence this, but none had been undertaken.

Surgery

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way but did not audit the effectiveness of the assessment. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. We saw in all patient records that we reviewed that pain scores were accurately recorded. We also noted alternative methods of assessing pain scores were used, we observed the Wong-Baker pain system for patients who were nonverbal or had reduced understanding in use on all wards.

Patients received pain relief soon after requesting it. All patients reported prompt pain relief and no patient reported being left in pain.

Staff prescribed, administered and recorded pain relief accurately. We saw no errors or omissions in the patient records that we reviewed.

We requested any completed pain audits, but none were provided.

Patient outcomes

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

The service participated in relevant national clinical audits.

Outcomes for patients were positive, consistent and met expectations, such as national standards.

Managers and staff used the results to improve patients' outcomes. We saw action plans that had been created following participation in national audits to monitor and continue positive outcomes for patients.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. We saw that since the last inspection the service had introduced a largely comprehensive audit programme but it did have some significant omissions such as pain.

Managers used information from the audits to improve care and treatment. We saw that the increasing trend in patient falls had been identified but noted a significant reduction following the introduction of falls avoidance information given to all patients on admission.

Managers shared and made sure staff understood information from the audits. We saw examples of how audit results had been shared with staff through email and in safety huddles.

Improvement was checked and monitored. We saw that all audit results had planned reviews and specific staff allocated to oversee the ongoing monitoring.

Competent staff

The service made sure staff were competent for their roles. Managers did not always appraise nursing staff's work performance. Meetings were held to facilitate training and development.

Surgery

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

Managers gave all new staff a full induction tailored to their role before they started work. Staff across all roles and grades spoke positively around the induction programme.

We were not assured that managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Data provided after our inspection visit showed poor appraisal completion figures across all wards and theatres.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Appraisal completion compliance across medical staff was 84% and whilst this was beneath trust targets it demonstrated an improvement from our last inspection.

The clinical educators supported the learning and development needs of staff. Staff reported overwhelmingly positive experiences with the practice developers.

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

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers told us that they would identify training or development needs for their staff and encourage them to pursue additional opportunities to improve.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. All staff told us that managers were keen to assist staff to develop within their roles.

Managers made sure staff received any specialist training for their role. All staff told us that they were given ample opportunities to undertake further training and competencies for their role

Managers identified poor staff performance promptly and supported staff to improve. Managers told us how they would assist a member of staff to improve, they detailed supervised practice and additional support whilst on shift and ensuring that they received all necessary training for their role.

Multidisciplinary working

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

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

We observed a multi-disciplinary patient review meeting and saw proactive contributions made by all members of the patient care team which included consultants, junior medical staff, therapists, radiologists and nurse specialists.

Allied health professionals (AHPs) worked closely with ward staff, junior doctors and pharmacists on most wards we visited. For example, a rotational physiotherapist on an integrated ward had working hours to match the nursing staff.

Surgery

Staff on the colorectal ward could access a surgical physiotherapist overnight and at weekends for patients who needed urgent chest physiotherapy or were at risk of deterioration. We heard about weekend physiotherapist referrals for laparotomy patients at the surgical assessment centre (SAC) alongside cover arrangements for occupational therapists and other staff trained to undertake therapy assessments.

Allied health professionals including occupational therapists, physiotherapists and speech and language therapists all provided care as part of each ward team and contributed to patient records. They participated in safety huddles on each ward.

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. In general surgery and urology there was a 7 day a week consultant led - post take ward round. All South Yorkshire regional services (SYRS) services had seven-day consultant ward rounds and on-site cover. All other wards had consultant led ward rounds five days per week.

Staff told us patients were reviewed by consultants depending on the care pathway. The service offered seven-day 24-hour discharge and the pharmacy was open seven days a week.

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

Health promotion

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

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

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Staff we asked gave patients information on managing their diabetes, pressure area care and smoking cessation to raise awareness and patients could be referred for smoking cessation support upon discharge.

Patients could be referred for substance misuse detox programmes where appropriate.

Wards we visited had lots of information available for patients on leaflet racks.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Surgery

At the previous inspection we saw that managers did not always monitor the use of Deprivation of Liberty Safeguards (DoLS) and did not make sure staff knew how to complete them and that staff did not always understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005.

At this inspection we saw that all managers monitored the use of DoLS and ensured that staff knew how to complete them. All staff were able to articulate their role and responsibilities and they all demonstrated understanding of the process. They could also tell us who they could seek advice and guidance from.

Since the last inspection the trust had introduced ward assurance visits and assurance was provided following these visits that all surgical wards are now following best practice. We reviewed the most recent assurance documentation and saw no errors or omissions had been recorded.

We reviewed five sets of notes where a patient was subject to DoLS and we saw no omissions or errors in any of the paperwork completed.

At the previous inspection we saw that cognitive assessments for patients with dementia had not been completed. At this inspection we specifically requested records of patients with dementia and we saw completed cognitive assessments in the six records that we reviewed.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We saw completed examples of capacity assessments within patient notes.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed staff seeking verbal consent before any interaction and we also saw consent being recorded appropriately.

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

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

Nursing staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. We were only provided with the training compliance at trust level which for nursing staff was 94% in excess of the trust target of 90%.

Clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. We were only provided with the training compliance at trust level which for clinical staff was 85% compared to the trust target of 90%. We did note that this was an improving picture.

Is the service caring?

Good ● ↑

Our rating of caring improved. We rated it as good.

Surgery

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness.

Staff followed policy to keep patient care and treatment confidential.

Feedback from people who used the service and those who were close to them was mixed. The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The trust provided Friends and Family Test data gathered from all surgical wards which ranged from 63% on Firth 9 to 96% on Huntsman 5. The trust had completed additional work on those highlighted wards where the score was beneath trust target and we saw an improving picture. It was noted that the number of responses greatly varied with less responses on those wards scoring less highly.

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

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

Emotional support

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

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

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

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

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

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. We saw interpretation services were readily available on all wards

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We noted that staff had access to communication cards if required.

Surgery

Staff told us that patients and their families could give feedback on the service and their treatment and staff supported them to do this. We did not see any information displayed in patient areas detailing how to give feedback or to make a complaint.

Staff supported patients to make advanced decisions about their care.

Staff supported patients to make informed decisions about their care.

Patients gave positive feedback about the service. We saw multiple examples of positive feedback received on all wards we visited.

Is the service responsive?

Requires Improvement ➔🡐

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

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the needs of the local population.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. No ward staff could tell us when they last had a mixed sex breach and data provided following inspection recorded no breaches.

Facilities and premises were appropriate for the services being delivered.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. Staff told us they had good communication systems in place with the mental health team to ensure timely intervention.

The service had systems to help care for patients in need of additional support or specialist intervention. We saw that staff had access to additional specialist equipment such as bariatric hoists and chairs.

Managers monitored and took action to minimise missed appointments.

The service relieved pressure on other departments when they could treat patients in a day. We saw that day surgery was offered for certain procedures which meant that admitting patients overnight would not be required.

Meeting people's individual needs

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

Surgery

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. We saw several examples of the 'This Is Me' document being used by staff on the wards we visited.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. All staff were able to tell us where they could access these resources.

Patients were given a choice of food and drink to meet their cultural and religious preferences. We saw that different diets were available such as halal and kosher.

Staff had access to communication aids to help patients become partners in their care and treatment. We saw communication cards on several wards that we visited.

Not all wards were designed to meet the needs of patients living with dementia. We raised this at the time of inspection, and we were told that there was an ongoing programme of work to refurbish the wards and that the refurbishment plans included making the wards meet the needs of patients living with dementia.

Access and flow

People could not always access the service when they needed it nor receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

Managers monitored waiting times and but could not ensure patients could access services when needed and received treatment within agreed timeframes and national targets. The trust had failed to meet any of the cancer two week wait targets in the previous 12 months. Overall trust referral to treatment times (RTT) were worsening with only 64% compliance in August 2022 compared with 72% in September 2021. We requested specific service and specialty data but this was not available.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. We saw that the trust cancelled on average one emergency service operation per month which was within national guidance.

Managers and staff worked to make sure patients did not stay longer than they needed to. The average length of stay was three nights which was within the national average.

Managers made sure they had arrangements for surgical staff to review any surgical patients on non-surgical wards. We were told that the consultant team responsible for the patient would ensure that they received the care required but it was unlikely for a surgical patient to be on a medical ward and no staff could give an example of it recently happening.

Surgery

Managers worked to minimise the number of surgical patients on non-surgical wards. At the time of inspection there were no surgical patients on any medical wards.

Managers worked to keep the number of cancelled operations to a minimum. We did note following inspection that cancelled elective operations were an ongoing concern with numbers increased over the previous 12 months. We did see that the trust had undertaken further work to remodel the elective surgery service to ensure that cancellations were reduced.

When patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. We saw that all cancelled surgery had been rebooked within 28 days.

Managers monitored that patient moves between wards/services were kept to a minimum. Managers and ward staff told us that patients were only generally moved if they needed to be located within a specialist area. We requested information regarding inpatient transfers but this information was not recorded.

Staff did not move patients between wards at night. Data provided following inspection highlighted that an average of two patients were moved at night.

Managers and staff started planning each patient's discharge as early as possible. Staff told us that discharge planning started when the patient was admitted.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Discharge planning featured within all multidisciplinary team meetings.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. The average number of delayed discharges per month were 38, this had a negative impact on access and flow.

Staff supported patients when they were referred or transferred between services.

Managers monitored patient transfers and followed national standards.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received but the information on how to do so was not easily accessible. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Staff were proactive in asking for feedback. We saw feedback boxes on each ward we visited but signage was inconsistent.

The service did not clearly display information about how to raise a concern in patient areas. We saw no obviously displayed information on making complaints in any patient area that we visited.

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

Surgery

Managers investigated complaints and identified themes. There had been 159 complaints made from September 2021 to August 2022. The main themes were unhappy with outcome of surgery, communication with patient and waiting for procedure. At the time of inspection 26 were open with one complaint response overdue. The average time to complete the process was 44 days.

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

Managers shared feedback from complaints with staff and learning was used to improve the service. An example of changes made following complaints to improve the service was increased accessibility to telephone interpretation services.

Staff could give examples of how they used patient feedback to improve daily practice. Patients had highlighted the risk of falling. We saw each ward provided falls prevention information and non-slip socks to all patients on admission.

Is the service well-led?

Requires Improvement ➔🡐

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

Leadership

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

Surgical services were separated into directorates so there were multiple leaders throughout the Trust. The theatre services managers had an overview of all surgery activity and the trust told us the medical director, Chief Operations Officer (COO) and deputy COO had overall leadership responsibility and were well sighted on all issues escalated to them.

Nursing leadership at ward level consisted of nurse directors who managed a team of matrons who managed two or more wards. These matrons managed nurses in charge of wards. Each care group had a Director of Nursing who reported to the Chief Nurse.

All staff spoke positively about senior leaders who reported that they were approachable and visible on the wards. Junior managers also spoke positively on how they were encouraged and supported to progress into more senior roles.

Vision and Strategy

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

Surgery

The Chief Operating Officer and deputies had the overall vision for the organisation with networks between directorates all the time. The operations director for care group operating service, critical care and anaesthetics (OSCCA) had a clear insight of the vision and strategy regarding operating pathways for surgical directorates.

Managers told us each surgical directorate had its own vision. There were different strategies and vision for each directorate. We saw that the trust had submitted separate strategies for all surgical directorates. This was part of 'New Trust Corporate Strategy - Making a difference - the next chapter 22-27'. This described all the separate areas for improvement and innovation for the surgical directorates at the trust.

Culture

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

All staff we spoke with told us that things were improving, and it was becoming a more positive environment to work in. There was an acknowledgement that things had been difficult for a number of years, but staff could see how things had been changing for the better.

All staff reported that everyone was there for the same reason and that was to ensure the best possible care for the patients.

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

Staff were able and encouraged to report incidents and make suggestions. They all reported being taken seriously and that their views were considered as valid as more senior staff.

All staff felt confident to raise concerns or to report incidents as they felt that it was not a punitive process and that incident reporting was used as a tool for learning.

Governance

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

The governance framework provided by the trust showed a range of trust wide groups and meetings that fed into governance processes. The trust provided minutes of governance meetings from several specialities which included information about performance, risks identified and engagement. Actions had been agreed and staff identified to address them.

We saw significant improvements since our last inspection in that the trust had implemented new systems to monitor compliance and had created new audits. These new systems were not yet fully embedded, but the current improvement and pace of change was positive.

Surgery

Management of risk, issues and performance

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

We saw that the provider had a risk register which had all identified risks, dates of entry, dates for review, mitigations and staff allocated to manage each risk. We were assured that senior staff escalated risks where necessary.

We saw robust systems and processes were now being utilised to manage performance. We were assured that the senior management team had sufficient oversight of performance to identify areas that required improvement.

Staff told us that their opinions were sought by senior management when decisions were needed to be made.

The pace of action within theatres in relation to never events was a persistent issue which demonstrated that the work undertaken was not yet fully embedded.

Improvements had been made since our last inspection, but we saw that there have been multiple areas where compliance towards trust targets has not been met such as in infection prevention and control audits and safety checklists in theatres.

We saw that data was collected both at a national and local level, but we were not assured that it was always utilized in a timely manner to make improvements. We saw that data was collected regarding ward infection prevention and control measures, but we saw no actions taken when compliance did not reach trust targets, this was particularly noted with ward based hand hygiene compliance.

Information Management

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

We saw that data was also collected in response to issues that had been highlighted through notifications regarding never events. We saw that work was undertaken to address the low compliance with surgery safety checklists. This work was still ongoing during inspection but data submitted showed consistent improvement.

The trust submitted all data and notifications to external organisations when required.

Engagement

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

Staff were engaged through the surgical services staff survey where issues were reported, and a subsequent action plan was created to improve staff experience through the People Promise. We saw completed examples of these action plans and found them to include outcomes, measures, timescales and allocated to senior staff to oversee.

Surgery

The Trust's patient engagement work was not site specific; the Trust had a patient experience group that oversees the trust's patient engagement activity and a quarterly report is then made available. In addition, the trust runs a patient first group which is made up predominantly of patients, governors and carers, and is co-chaired by two patients. A small number of staff attend to ensure that feedback from the group can be fed into programmes of work. The group acts as a reference group for gaining engagement in service developments.

Learning, continuous improvement and innovation

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

All senior leaders were able to articulate the need for continuous innovation and improvement as well as understanding of quality improvement methods and the skills to use them. Examples given included introducing and improving cross professional group working with innovative treatments following a collaborative piece of work across specialities and also specific improvements in vascular services which have improved patient care.

Care Quality Commission

Jessop Wing

Tree Root Walk
Sheffield
S10 2SF
Tel: 01142711900
www.sth.nhs.uk

Description of this hospital

The Jessop Wing is one of sixteen locations where Sheffield Teaching Hospitals NHS Foundation Trust provides care.

During this inspection we inspected and rated the following core services at this location:

- Maternity

The Jessop Wing opened in 2001 and is a purpose-built maternity unit with approximately 6200 babies born at the service every year.

In addition to a 22-bed labour ward, there are two postnatal wards, one antenatal ward, an admission triage area and an advanced obstetric care unit. One of the postnatal wards specialises in caring for women who have had a caesarean section. In addition, the Jessop Wing community midwifery service supports approximately 80 homebirths per year.

The Jessop Wing also provides neonatal intensive care and special care for sick and premature babies born in Sheffield and those transferred from other units who require this service.

Maternity

Requires Improvement ↑

Is the service safe?

Requires Improvement ↑

Our rating of safe improved. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff and monitored compliance. Not all staff were fully complaint with all mandatory training.

The mandatory training was comprehensive and met the needs of women and staff. At the time of this inspection, there was evidence that face-to-face multidisciplinary team (MDT) training had re-commenced which was in line with best practice guidance

Staff compliance with mandatory training had improved since the last inspection. Data provided by the service showed that medical staff were compliant with most elements of mandatory training against a service target of 90% (MCA and DoLS). Midwifery staff were not fully compliant with all mandatory training, including safeguarding, Mental Capacity Act and Deprivation of Liberty Safeguards.

During this inspection we were advised that most areas of training had returned to face-to-face sessions following COVID-19.

Obstetric emergency drills practical obstetric multi-professional training (PROMPT), fetal monitoring and neonatal life support (NLS) were identified as the greatest focus for improvement by the trust to ensure the quality and safety of maternity services. Matrons for each area undertook a focused 1-1 with staff whose training was overdue to support and facilitate access and time to undertake training during the months May to September 2022. Compliance rates were managed, monitored, and reported weekly to the triumvirate. Overall PROMPT training compliance for midwives was now 95% and obstetricians 90% against a target of 90%.

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

Managers now had a system to monitor mandatory training and alerted staff when they needed to update their training. Priority has been given in the allocation of training to midwives working in the intrapartum environment first, followed by antenatal wards and then other staff.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Midwifery staff were not fully complaint with training on how to recognise and report abuse.

Medical staff received training specific to their role around how to recognise and report abuse. Both safeguarding adults and children training compliance rates were 90% against a target of 90% as of September 2022. This is an improvement from the previous inspection.

Maternity

Midwifery safeguarding adults training compliance rates were 90% against a target of 90%. However, figures showed compliance rates for level 2 and 3 safeguarding children training were 72.2% and 71.9% against a target of 90% as of September 2022. Although not meeting the target, this was an improvement since the previous inspection. It was recognised that the audience for safeguarding and the level of safeguarding training has been altered due to staff rotation, which has affected the planned trajectory.

The service had a team of midwifery staff specialised in managing vulnerabilities. The team were responsible for overseeing women who were identified as having a safeguarding concern and ensuring that the appropriate support and authorities were involved in women's care.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The service followed the Family Common Assessment Framework (FCAF) (incorporating threshold of need guidance) and referral to the local safeguarding hub.

Safeguarding adult and children's policies were in place, in date and in line with intercollegiate guidance.

Staff had access to practice guidelines such as, but not limited to, female genital mutilation, domestic abuse, referral to the local safeguarding hub, management of substance misuse in pregnancy: identification and provision of care and substance misuse in maternity: care of the baby.

During this inspection we were informed that the baby abduction drill had taken place. Babies also received a tag which alerted a dashboard in the midwife office base, should it come loose or be removed from the ward.

Cleanliness, infection control and hygiene

Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean. However, audits of cleanliness continued to lack detail and were completed inconsistently.

Staff cleaned equipment after patient contact and labelled equipment and furniture with 'I am clean' stickers to show when it was last cleaned. Ward areas were clean and had suitable furnishings which were clean and well-maintained.

Cleaning schedules were in place and demonstrated how areas were cleaned regularly and we observed regular cleaning for which everyone took responsibility. Not all signage within units or compliments cards were protected in a way that would enable them to be wiped down easily.

Staff followed infection control principles (IPC) including the use of personal protective equipment (PPE). Staff now adhered to IPC principles and all staff seen were bare below the elbows in ward areas. There were adequate supplies of PPE, hand gel and washing facilities available.

Audits of IPC procedures continued to be completed inconsistently and varied in meeting compliance targets across wards. Hand hygiene audits between January and August had only been consistently completed each month for the midwifery led labour ward and Rivelin ward. Hand hygiene audits were not completed consistently for Whirlow ward. Staff had not audited cleanliness on Rivelin or Whirlow wards, although staff on Norfolk ward had completed monthly cleanliness audits for the previous three months.

Audits completed by all wards met the targets of 100%, however we did not receive audit information to include number of observations undertaken or what observations had included to achieve this.

Maternity

The latest standard precautions audit, an audit of activities used by all healthcare workers to reduce the risk of transmission of micro-organisms, conducted in September 2022, saw all five wards reviewed during inspection achieve 100% compliance with hand hygiene, personal protective equipment, aseptic non-touch technique, safe disposal of sharps and clinical waste and linen disposal.

Environment and equipment

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

The design of the environment was suitable for the needs of women. There were three theatres on the unit, adjacent to the labour ward and the neonatal unit, with one reserved for emergencies, these were located near the AOCU and neonatal units.

The triage area had been restructured since the October 2021 inspection. During this inspection we saw rooms designated for women waiting for triage and clinical assessment and we did not observe women waiting lengthy periods of time or in the corridors. There was an electronic system in place which showed the waiting area on a screen for staff to monitor. This allowed staff to reserve chairs in the triage area for women who had telephoned the labour ward prior to attending. Staff were able to see both who was in and about to arrive to the labour ward and how they had been triaged.

The service had enough suitable facilities and equipment to meet the needs of women and their families. There were three additional birthing pools available since the last inspection. The bereavement room was comfortable and able to be adapted to the needs of women. There were side rooms allocated for women who required someone to stay with them and waiting areas with communal kitchen facilities for visitors.

Resuscitation trolleys, including those in theatre, now had daily checks in place that were completed by staff. Emergency boxes such as post-partum haemorrhage (PPH), pre-eclampsia, and cord prolapse were accessible, checked frequently and stocked appropriately. All equipment was working, and items had not exceeded their expiry date.

Women could reach call bells and they told us staff responded quickly when called.

We observed staff dispose of clinical waste safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman however, documentation did not always effectively identify women at risk of deterioration

Staff used a nationally recognised tool to identify women at risk of deterioration however, the way these were used made it difficult to monitor patient deterioration across the maternity pathway. Intrapartum observations were recorded on a paper partogram, a graphical record of key maternal and fetal data, this did not give a scoring system to the condition of the patient. Midwives then referred to a poster to calculate the modified early obstetric warning score (MEOWS).

MEOWS before and after labour were recorded electronically on the electronic white board making it potentially difficult to recognise a trend in deteriorating woman, particularly if deterioration started intrapartum and worsened post-delivery. Staff told us that recording scores in two formats and different places posed a potential issue that would hopefully improve when the service introduced a full electronic system.

Maternity

The service had introduced the Birmingham symptom-specific obstetric triage system (BSOTS) to better assess and treat women quickly. The system involved completion of a standard clinical triage assessment by a midwife within 15 minutes of the woman's attendance to define clinical urgency using a 4-category scale. Early data showed that over 95% of women were triaged in an average time of 20 minutes.

There was a triage midwife assigned to the assessment of women waiting in the labour ward with oversight of the waiting area to monitor women for any changes in presentation. Staff we spoke with were familiar with how to use BSOTS despite it being newly introduced and spoke proudly about its implementation. Staff also triaged women over the phone. If a decision was made for a woman to come into the ward, they would be triaged using a virtual waiting room so that all women that would be attending that day were triaged by clinical urgency.

During the previous inspection, CQC identified that the service did not have a process to prioritise the transfer of women to the labour ward. During this inspection we found that a tool had been developed but was not used consistently due to staffing. The service had audited the labour ward prioritisation tool and found that over the 4-week period since its implementation (August 2022 to September 2022) 1206 women attended LWAU and 861(72%) had a rapid review and prioritisation RAG rating applied.

An additional new ward prioritisation tool was held electronically and manually updated by midwives based on a woman's Modified Early Obstetric Warning Scoring (MEOWs) observations, CTG findings and fetal movement concerns. The tool was visible on all wards and enabled the antenatal ward to highlight the changing needs of women. The consultant-led labour ward used the tool to prioritise moves to the labour ward. However, there was no alert on the system, and it required periodic review to identify and flag priority changes.

Fetal heartbeat monitoring continued to improve since our last inspection. The service had appointed a fetal monitoring lead who based the approach to fetal monitoring on nationally recognised guidelines. They chaired a CTG monitoring meeting once a month and conducted a weekly spot check of 10 notes for fresh eyes which showed 81% compliance. An internal CTG audit undertaken by the service of 21 standards, highlighted the following findings:

- Six standards achieved above 95%, including date, time, event or second opinion documented, hourly assessment documented in labour record, CTG stored in CTG envelope, envelope labelled with woman's identifiers.
- No standards were now below 25%. One standard was at 30% which was the reason for ending CTG documented in notes.
- The audit showed that the Intrapartum Review tool sticker was fully completed in 50% of cases.

Managers continued to work to keep the number of delays to a minimum by using the red flag system. If a midwifery red flag event occurred, the midwife in charge of the service or shift would be notified. We observed that red flags were recorded, for example if there was a delayed or cancelled time critical activity.

Shift changes and handovers included all necessary key information to keep women and babies safe. A safety huddle had been specifically adapted and introduced for midwifery services; these were short meetings that captured key information discussed at the beginning of each shift on each ward. They included information such as escalations, babies of concern, mental health concerns, critical medications, inductions, incidents and learning, nutrition and hydration including diabetes and wellbeing of staff.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. Woman assessed at risk would be overseen by the vulnerabilities team. The service had 24-hour access to mental health liaison and specialist mental health support.

Maternity

Staff completed the World Health Organisation (WHO) safety checklist, a set of checks performed before any operation to increase patient safety, these were completed in full for all records reviewed. Managers carried out audits of the WHO checklist usage, this consisted of five observations against all the questions in the checklist. We saw evidence of the audit identifying areas for improvement; however, this did not include an action plan.

During our previous inspection we were advised that there were often difficulties requesting additional assistance when women deteriorated. Staff told us that there were occasions when they would 'bleep' for medical assistance on more than one occasion before assistance arrived. During this inspection we found that there had been a specific emergency bleep number allocated for deteriorating women. We were advised this had improved support, response times and intervention.

Midwifery staffing

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

To provide a safe maternity service, the Royal College of Midwives (RCM) says there should be an average midwife to birth ratio of one midwife for every 28 births. The midwife to birth ratio had improved from the previous year. In July 2021 the birth ratio was 1:30 in comparison to 1:27 in July 2022. In August 2021 the birth ratio was 1:31 in comparison to August 2022 which was 1:26. We found that staffing levels met national guidelines.

The trust used the maternity red flag process to report any occasions when a midwife was not able to provide continuous 1:1 care and support to a woman during established labour. This was reported by the labour ward coordinator on Birthrate Plus every four hours. The midwifery leadership team had access and oversight including escalations and mitigation. We reviewed red flag data covering a three-month period. There were no red flags relating to 1:1 care in June and August and there were five in July 2022.

The service had a nursing and midwifery staffing escalation policy in place. The policy detailed how to address any shortfalls in staffing, for example, unexpected absence. An escalation plan via the senior nurses and midwives on duty or relevant on-call teams was clearly defined. A report was discussed at twice daily nurse staffing meetings to consider the plans for staffing over the following 24-hour to 48-hour period.

When there were identified challenges to safe staffing, we were advised that the following steps were taken, for example, midwifery staff allocated specialist roles would work clinically, elective workload was prioritised to maximise availability of staffing; managers at band 7 level and above would work clinically; staff were relocated to ensure 1:1 care in labour and dedicated supernumerary labour ward co-ordinator roles were maintained. The on-call midwives from the community would support labour ward during times of escalation. In addition, we were advised that the Jessop Wing employed registered nurses to fill shifts on the post-natal ward and AOCU. Staff said this supported the medical needs of women post caesarean section.

We discussed the red flag system with ward staff and found that most could verbalise the processes. We gained further assurance that the process was robust and embedded when we observed red flag discussion at the daily safety huddle and when speaking with the leadership team. We found this had improved since the last inspection.

Ward coordinators were supernumerary, which gave a more accurate picture of staffing on duty and whether there was adequate staff planned for number of women and level of acuity. Red flag data for August showed that there were nine occasions where co-ordinators had to be included in the staffing numbers to support staff.

Managers preferred to use their in-house bank and recruited agency staff as a last resort. When agency staff were used, familiar staff were requested for each service. We were not assured that agency staff had a full induction and understood the service.

During the last inspection it was highlighted that the service was one of the first maternity units nationally to successfully implement an apprenticeship scheme for maternity support workers (MSWs). A cohort of 11 MSWs completed the 18-month senior healthcare support worker level three apprenticeship. Combining practical hospital experience with learning at a local college, the apprenticeship offered the opportunity to gain skills and knowledge specific to maternity care. The scheme was supported by the Royal College of Midwives. During this inspection we were advised that the MSW scheme had been successful and that a second cohort would be commencing.

Medical Staffing

The service had enough medical staff. The medical staff in post had the right qualifications, skills, and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep women and babies safe. There were 2905 births in six months to September 2022 with 21.75 whole time equivalent consultant obstetricians in post. The ratio of consultant to birth was one consultant to 279.7 births. This fell within national guidelines. All medical shifts had been covered over the previous six months (April to September 2022), however this did include a high level of long-term locum usage to fill rotas.

The Jessop Wing is a tertiary centre specialising in caring for complex pregnancy and childbirth. As a consequence, complex births from around the region transfer to Jessop Wing resulting in a very high acuity (level of care) of patients. We were informed during our interviews that the service required two additional obstetricians to manage acuity levels. These positions had been advertised but not successfully filled.

Information provided highlighted that many measures had been taken to mitigate risk, such as the addition of two extra locums, ST3+ (speciality training) and existing team being utilised to cover labour ward / on call gaps and ST1/2 locums in post to offset the gap.

The Jessop Wing's planned consultant cover was 24 hours per day, seven days per week with an additional on call consultant. The service did not always have enough staff for consultant night shift cover, with only one month between October 2021 and September 2022 having a consultant on every night shift. However, there was always an on-call consultant available.

There was an operational process to cover absence. We were told that from Monday to Friday the clinical administration team used the 'Managing Staffing Shortages OBS & Gynae Theatres standard operating procedure (SOP)' to ensure the emergency services, including the elective sections, were prioritised if an absence was reported. There were processes in place to support staff in contacting medical colleagues out of hours including a messaging group.

Data showed that 70% of women received an epidural within 30 minutes of requesting. Staff told us this delay was often caused by a second consultant being required to come from home on request for epidural.

Records

Staff did not always keep detailed records of women's care and treatment. Records weren't always clear, up-to-date, stored securely and easily available to all staff providing care.

Maternity

We reviewed 13 women's records during the inspection and found that records were held on multiple systems which did not flow effectively. To have a full overview of a woman's records staff had to access different systems. The service planned to implement an electronic recording system for all documentation within the next two years. Following feedback from the previous inspection, risks were identified in certain areas where a hybrid of electronic and paper based data collection was in place. Managers were in the process of reverting to one paper based record in these areas.

Records were often duplicated, and staff could not explain the reason for this. Discharge paperwork was completed manually and included a summary for mum, summary for baby and a separate electronic copy.

When women transferred to a new team, there were no delays in staff accessing their records. Following the last inspection, antenatal records had been incorporated within post-natal records and included risks relevant to the mother across the maternity pathway.

At the previous inspection it was highlighted that the Healthcare Safety Investigation Branch (HSIB) had recommended 'the service is to ensure that all antenatal assessments and identified risk factors are fully documented in the patient records in line with the Nursing and Midwifery Council (NMC) and the General Medical Council (GMC) standard'. A review of 10 of the most recent HSIB reports showed that documentation had improved and was no longer a repeated recommendation.

The service no longer had a specific internal audit to review the standards of record keeping. We were told that quality of record keeping was looked at within other audits, for example the CTG audit looked at how well records had been kept in relation to CTG's.

In six of the 13 records we looked at fetal growth had not been recorded. However, we saw that this had not influenced the care women received, for example, one record demonstrated a woman had been admitted for induction of labour due to reduced fetal growth, despite this not having been recorded consistently.

During this inspection we observed that the application of the 'fresh eyes' approach was more embedded. Staff were now 90% compliant with CTG training, we saw staff monitoring CTG in practice and reviewed the documentation in records. There was an appointed fetal monitoring lead who conducted a monthly CTG meeting and regular audit of records to ensure 'fresh eyes' was being recorded.

Records were not always stored securely. Maternity records were stored in the midwife's office, within the maternity unit. The records were not locked during our inspection; however, records were in constant use.

Medicines

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

Staff did not always follow systems and processes to prescribe and administer medicines safely. Controlled drugs (CD) were securely stored and were in date, medications were stored at the correct temperature which was recorded daily. However, time-critical medications were not always prescribed or administered in a timely way. In the last audit of time critical medication completed in May 2022, 20% of critical medicines had not been prescribed and that 23% were not administered on time.

Maternity

The process to ensure the safe storage of emergency medicines had improved since the last inspection. Emergency trolleys had been checked and did not contain out of date drugs. Emergency medicines were stored centrally for staff to access easily. All items in the post-natal ward post-partum haemorrhage (PPH) box were in the box, in date, tags checked, and matched the check sheet.

Staff completed medicines records accurately and kept them up-to-date. Information about women's medications were documented in care records and handovers to ensure they received the correct medications when moved between services.

Staff stored and managed all medicines and prescribing documents safely. Patient group directions, a written direction that allows the supply and administration of specified medicines, by a named authorised health professional, to a defined group of patients (PGD's), were visibly listed on storage cupboards to display medications midwives could administer without prescription to minimise the likelihood of errors.

Staff learned from safety alerts and incidents to improve practice. In response to an incident of medication going missing, the service had begun counting and administering all medications using two members of trained staff, they had also installed a camera into the medication room.

The service ensured women's behaviour was not controlled by excessive and inappropriate use of medicines. Staff ensured they were familiar with women's needs and followed the instruction of the perinatal mental health team when applicable before considered administering sedatives.

Incidents

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

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff spoke positively about a change of culture towards incident reporting and how this was to improve services and not to apportion blame to any one person.

The service reported 2,374 incidents from October 2021 to August 2022 inclusive. Out of the 2,374 incidents 1,904 were graded as no harm, 265 were low harm, 145 were moderate harm, and 11 were severe harm. This is an increase of 1,779 incidents from the same reporting period at the last inspection, highlighting an improved reporting culture.

The service had recently developed a tracker for incidents, this included incident details, duty of candour (DoC), deadlines for investigation, serious incident group dates, quality and safety team notes and necessary actions to ensure future risk was mitigated in a timely way.

The incident management policy had been reviewed since the last inspection and now reflected actual or suspected serious incidents and any never events which required escalation to the healthcare governance team within one working day of identification. There was one never event within obstetrics in the 12 months prior to our inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Maternity

Incidents were reviewed at the rapid review meeting prior to escalation at the service serious incident group (SIG) and reviewed by the quality and safety team. Terms of reference were now in place and meetings were undertaken when quorate.

Staff demonstrated an understanding of the duty of candour (DoC). They were open and transparent and gave women and families a full explanation when things went wrong. We saw examples of incidents and complaints where people had received appropriate DoC, however we did not see evidence of staff training in investigating incidents or DoC

Staff received feedback from investigation of incidents, we saw immediate learning being shared in daily safety huddles. Managers used multiple formats to communicate messages with as many staff as possible, this included emails, bulletins, daily huddles and within the staff secure social media page. Managers were revising posters used to communicate learning as staff had fed back these were not the most effective method.

Managers investigated incidents thoroughly. Women and their families were involved in these investigations. Findings from investigations informed what audits would be undertaken, for example, the service were doing weekly audits to ensure completions of MEOWS records. However, staff told us that although investigating the backlog of serious incidents was a priority, they were not given additional time to conduct these. There were 25 incidents progressing in August 2022 which were anticipated to be in the final stages by the end of October 2022.

Is the service effective?

Requires Improvement ● ➔ 🡐

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

Evidence-based care and treatment

The service was providing care and treatment based on national guidance and evidence-based practice.

All policies reviewed and remained within national guidance apart from the management of diabetes which had not been reviewed since August 2021 and consent to examination or treatment policy which was reviewed in May 2020. All policies were available for staff to follow on the intranet.

There was a perinatal mental health liaison service within the vulnerabilities team who attended the wards if needed, and when concerns were raised about a woman. The perinatal midwives also provided follow-up support on discharge. There were mental health nurses and vulnerabilities midwives who provided support and referrals to mental health services when required.

Since the last inspection, formal monitoring of mental health needs of women on the maternity unit had been introduced. If staff had concerns about a woman's mental health, there was now a mental health risk assessment and perinatal mental health pathway to follow to ensure their mental health needs were met in a timely way.

Staff attended handovers for information relating to their ward for each shift. Handovers had been reviewed and were specific to maternity services, this included the mental health needs of women, gestational diabetes and any pregnancies of concern.

Maternity

The Saving Babies Lives Care bundle, Version 2 (SBLCBv2) is a series of measures introduced by NHS England in 2019 to help reduce perinatal mortality. The trust had difficulty evidencing compliance with SBLCBv2 due to the varying methods of record keeping. Staff provided assurances such as, but not limited to, guidelines for fetal growth monitoring, training compliance and audits of Perinatal Institute Growth Assessment Protocol (GAP) and Cardiotocography (CTG), a technique used to monitor fetal heartbeat, usage for women presenting with reduced fetal movements. A fetal surveillance matron was to commence in post in October 2022 to lead on ensuring compliance. Fortnightly meetings were being held in the interim to review actions.

Nutrition and hydration

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

Specialist support from staff, such as dietitians were available for women who needed it. Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs. We observed support staff taking a variety of foods and drink to women regularly and they demonstrated awareness of culturally appropriate foods.

Women were able to bring their own food and drinks and there were now facilities for women and their families to re-heat food. Women requiring something to eat between meals were offered snacks provided by the ward.

We observed women being given a choice of food and drink to meet their cultural and religious preferences.

Nutritional information was included in staff huddles to ensure all staff were aware of women's dietary needs. We saw evidence of staff completing food and fluid charts for women when required.

There were leaflets available on promoting healthy pregnancy, post-natal exercise, infant feeding plans for parents as well as breastfeeding and formula feeding guidance.

The service had an infant feeding team to give women advice and support on feeding their baby safely.

There were expressed breast milk (EBM) fridges on the postnatal ward for women to store milk for their baby. Women had access to the fridges as and when required.

Pain relief

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

Staff assessed women's pain using a recognised tool during labour and gave pain relief in line with individual needs and best practice.

Staff gave women pain relief in the form of medications soon after requesting it, we observed several requests from women requesting pain relief on wards and this was provided in a timely way. Feedback from women had improved and did not highlight any delays in women receiving analgesia.

Staff prescribed, administered and recorded pain relief accurately.

The service did not frequently monitor time between women requesting pain relief in the form of epidural and receiving it. We requested audit data from the provider and received audit data from April to December 2021, this showed that 71.7% of women received epidural in line with national standards.

Patient outcomes

Staff monitored the effectiveness of care and treatment. However, timeliness of reviews and implementation of change was variable, which delayed improved outcomes for women.

The number of caesarean sections (CS) rate remains higher than the national average, however, has remained relatively stable. We were advised that the rates continue to be monitored and relate to complexity of the case mix and women's choice.

The service had a higher than expected readmissions rate than the England average. There were 187 unplanned maternal readmissions within 42 days of discharge between October 2021 and August 2022. The highest month for unplanned readmissions was August 2022 with 24. This had slightly improved from the previous year. These figures do not include women returning to triage or 'healthy lodgers' (when the baby is on the neonatal unit and mother is required to stay).

We were informed that all neonatal deaths were reviewed by a multidisciplinary group using the Perinatal Mortality Review (PMRT) Tool. This tool was designed to support high quality, standardised, multidisciplinary perinatal reviews observing the principle of 'review once, review well'. Each review considered all care provided leading up to and surrounding each stillbirth or neonatal death. We reviewed nine sets of minutes from the PMRT meetings and found that meetings were well attended. However, discussion could not be followed as the minutes were minimal with reference to an audio transcript for history, discussion, and grading of care. There was no evidence of following up of actions from previous meetings.

Managers and staff carried out a programme of repeated audits to check improvement over time. Several audits and projects were undertaken by the obstetrics, gynaecology and neonatology directorate audit programmes. The service told us all projects had been through the service's clinical effectiveness committee and subsequent actions identified from the projects had been followed up to completion. All projects were now considered 'complete' and appropriate re-audits had been set or were already in progress.

The trust had improved the maternity dashboard since the last inspection. Whereas previously the dashboard did not benchmark the service against national indicators, it now provided a RAG (red, amber, green) rating against national indicators.

The dashboard was maintained monthly (a month behind) and reported on clinical outcomes such as level of activity, maternal clinical indicators (mode of delivery, trauma during delivery (including postpartum haemorrhage and perineal trauma), neonatal clinical indicators (cot acuity, preterm delivery), induction of labour, public health information and stats analysis.

The service participated in relevant national clinical audits. The service had contributed to the National Neonatal Audit Programme, MBRRACE UK (mother and baby: reducing risk through audits and confidential enquiries), maternal, newborn and infant clinical outcome review programme, National Maternity and Perinatal Audit and ATAIN (avoiding

term admissions into neonatal unit). However, the trust stated that full compliance of all Ockenden immediate and essential actions (IEA) would continue to be compromised by the on-going lack of an integrated and effective Maternity Information System (MIS) to both guide practice, record evidence of actions undertaken and report on compliance through robust audits.

Maternity Dashboard

From October 2021 to August 2022 the maternity dashboard data showed 31 stillbirths. However, it was not indicated on the dashboard if these occurred during pregnancy or during labour or if there were any precipitating factors which led to the stillbirth. Whilst the current regional data demonstrated that stillbirth rates at the trust were similar to those of the other tertiary centres in the Yorkshire and Humber region, a thematic review undertaken in May 2022 had identified the opportunity to further improve practice and further reduce the risk of stillbirth.

The maternity dashboard showed the induction of labour rate was in line with national benchmarking at 25.47% at the time of inspection.

Data for the trust showed from October 2021 to August 2022 showed the average proportion of women who had a normal delivery experienced a third or fourth degree tear was 3.5%. This was slightly worse than the 3% target. Over the same period, the average proportion of women who had an assisted delivery and experienced a third or fourth degree tear was 3.9%. Data showed that the trust were better than the 5% target.

As of August 2022, the number of women who experienced a postpartum haemorrhage of greater than 1500mls at the hospital was 4.3%. This remained worse than the 3% target but was an improvement from figures reviewed at the previous inspection.

The trust had an emergency caesarean section rate of 26.9% which was higher than the national average of 15.8%. The elective caesarean section rate of 16.8% which was higher than the national overage of 13.3%. These figures were similar to findings at the previous inspection.

Audit results were requested for the monitoring of epidural wait times, and an audit between April and December 2021 was provided. This supported that the service was meeting national standards which state that women should receive an epidural within 30 minutes of women requesting them, unless in exceptional circumstances. Epidurals were given to women in under 30 minutes in 71.7% of cases. Although this is within national standards, staff told us delayed wait times were due to waiting for the on-call consultant.

Competent staff

The service worked with staff to improve their competency for their roles. Managers did not always undertake timely staff appraisals of work performance.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. We reviewed training data which showed that both midwives and medical staff were compliant with mandatory skills and drills training target of 90% with midwife completion rate of 94.3% and medical staff 92.1%, this included practical obstetric multi-professional training (PROMPT) training.

Managers had begun to appraise staff's work performance since the last inspection. Appraisal rates were 63% for clinical staff, 77% for medical staff and 63% for nursing and midwifery staff against a target of 90%. Although the service had not achieved the trust target for supervision, this was an improving picture, the service had also recruited new staff and just had a clinical rotation affecting the amount of appraisal's undertaken in the service.

We reviewed the National Reporting and Learning System (NRLS) between October 2021 and August 2022 and found 28 reports of lack of suitably trained/skilled staff. All 28 incidents were reported as no harm to patients. The reported incidents of lack of suitably trained/skilled staff had reduced by four since the last inspection. A training plan had been implemented to address training delays resulting from COVID-19 following the last inspection. We were advised that live skills and drills training had recommenced.

We were informed that managers gave new midwives a full induction tailored to their role before they started work. Staff were provided with a comprehensive induction and preceptorship logbook which provided information in relation to the preceptorship programme, what was expected of the staff member, linked strategies, each training element of the programme, and final sign off induction and preceptorship. However, there was no timeline or targets to achieve the competencies attached to the programme.

Staff stated there was support available from the practice educators in developing and building their midwifery skills. During the previous inspection many midwives stated that they remained a band 5, rather than progressing to band 6 due to the lack of access to specialist tasks such as perineal suturing, and the administration of intravenous (IV) medicines. We were advised that this had improved, and band 5 staff had been able to access the necessary supervision and competencies.

We were advised that learning and development had received good operational support since the last inspection. Staff had allocated time for training including practical obstetric multi professional training (PROMPT) and Cardiotocography (CTG) training, resulting in compliance with the 90% target. Training session were now linked with the 'off duty' so that staff were allocated training in advance, meaning that staffing would remain adequate on the unit.

Fetal monitoring training had been delayed due to external difficulties within the Local maternity and neonatal system (LMNS). The first full study day now planned for the 14 December 2022 and has been locally organised rather than being undertaken regionally. This ensured the training could be delivered quicker.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. We were informed of a midwife proactively seeking an external course, to benefit the Jessop Wing, and being granted funding.

Multidisciplinary working

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

Staff told us the working relationship between midwifery and medical staff had improved with a clearer focus on safety.

Staff worked across health care disciplines and with other agencies when required to care for patients. We saw evidence of cross agency working by means of the Yorkshire and Humber (Y&H) maternity focus group which ensured a core set of indicators relevant to maternity services in the Y&H region were reviewed to improve quality and performance

Maternity

Managers were engaging with external agencies to improve maternity services for women, NHS England's maternity improvement advisors gave positive feedback about how the service had begun to grow at a sustainable rate.

Staff referred women for mental health assessments when they showed signs of mental ill health, depression. We saw examples of appropriate referral to the perinatal mental health team and saw staff using the team's advice in practice to support women experiencing mental health issues.

Staff were leading multi-disciplinary working groups to drive improvement in specific areas by implemented evidence-based approaches into working practices such as governance.

Seven-day services

Key services were not always available seven days a week to support timely care.

There was consultant-led daily ward rounds on all wards, including weekends. Women were reviewed by consultants depending on their care pathway.

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

However, consultants required for administering an epidural were not always onsite, staff were able to call the on-call consultant, but this meant women sometimes had to wait over 30 minutes until they arrived onsite to receive an epidural.

Health Promotion

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

Women were offered smoking cessation support by the specialist midwifery stop smoking service.

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

Staff assessed each woman's health when admitted and provided support for any individual needs to live a healthier lifestyle such as obesity and diabetes.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health.

Women told us staff gained consent from them for their care and treatment and we saw this recorded in women's records.

The service's consent to examination or treatment policy had not been reviewed since the 1 May 2020, however referenced relevant legislation and guidance, including the Mental Health Act 1983, Mental Capacity Act 2005. This meant staff understood consent and decision-making requirements and were given details of who to contact for advice.

Maternity

As of September 2022, training figures showed a midwife compliance of 77.2% for Mental capacity Act (MCA) training and 80% for Deprivation of Liberty Safeguard training (DoLS). This had greatly improved since the last inspection. At the time of inspection, the consultant compliance rate for MCA and DoLS training was 85.4%.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. When patients could not give consent, staff made appropriate capacity assessments and involved all relevant people and agencies in a women's life to ensure decisions were made in their best interests, considering their wishes and preferences. We saw an example where advocacy and social care support agencies had been involved ante and postnatally to ensure a woman lacking capacity was as involved in the decision-making process as much as possible.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Guidance was available on the use of Gillick competence and when to use this.

All women we spoke with told us they had all options throughout their pregnancy discussed with them before making decisions.

However, we were not to be assured that managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary due to the ongoing development of records and governance structure.

Is the service caring?

Good ↑

Our rating of caring improved. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way. Women told us they did not often require their call bells as staff regularly attended to see if they required anything.

Women said staff were amazing and treated them with kindness. One woman we spoke with told us about her delivery experience in comparison to her previous pregnancy, she told us, "it was better than last time, I can feel a clear difference… its more caring and organised."

Staff followed policy to keep women's care and treatment confidential.

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

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

Maternity

Emotional support

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

Staff gave women and those close to them help, emotional support and advice when they needed it. We spoke with a woman who had experienced a difficult birth, and the midwife present in the delivery stayed after their shift had ended to support her. She described staff as comforting and emotionally support. Staff had immediately given mother and partner resources for psychological support.

Staff where able to access bespoke bereavement support for women and their families when required. Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. There was access to bereavement rooms for families, these included cameras that immediately printed images for families to capture memories.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them, they involved friends and family in people's care to ensure women were as comfortable as possible.

Women were appropriately placed on wards and there were greatly reduced number of bed shortages.

Understanding and involvement of women and those close to them

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

Staff made sure women and those close to them understood their care and treatment. The service offered a 'keeping in touch service,' for families to send letters and photos to their loved ones, if unable to visit the unit, to be printed and framed.

Feedback from patients had improved, one woman we spoke to said, "I feel everything was my choice."

Staff supported women to make informed decisions about their care. We saw examples of women experiencing their first pregnancy having options explained to them and being asked about their preferences throughout their pregnancy.

Staff were able to talk with women, families and carers in a way they could understand, using communication aids where necessary.

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

Is the service responsive?

Requires Improvement ● ↑

Our rating of responsive improved. We rated it as requires improvement.

Maternity

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the needs of the local population.

Facilities and premises were appropriate for the services being delivered. Three theatres were available to enable there to be a dedicated elective and emergency caesarean section theatre. The bereavement suite was decorated to feel comfortable despite being in a clinical area.

Staff could access emergency mental health support from a neighbouring service 24 hours a day seven days a week for women with mental health problems, learning disabilities and dementia.

The service had systems to help care for women in need of additional support or specialist intervention such as diabetes, endocrinology, haematology, neurology, rheumatology, renal and cardiac.

Staff followed policy to ensure that women who did not attend appointments were contacted.

The service was actively involved with the Maternity Voices Partnership (MVP). The MVP is an NHS working group and includes a team of women and their families, commissioners and providers (midwives and doctors) who have worked together to review and contribute to the development of local maternity care, based on local needs. We saw evidence of the MVP members attendance at maternity governance meetings, co-design of patient information leaflets May 2022 onward and planned MVP attendance at all interviews of senior midwifery positions.

The Jessop Wing had disabled access and there were facilities for people with a disability.

Meeting people's individual needs

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

Managers made sure staff, women, loved ones and carers could get help from interpreters when needed. We saw signage and information leaflets available in languages spoken by the woman and the local community.

Staff understood and applied the policy on meeting the information and communication needs of women with a disability or sensory loss.

Staff made sure women living with mental health problems, and learning disabilities, received the necessary care to meet all their needs. For one woman who had a history of mental health diagnosis, staff had placed mother and baby in a side room in which her partner could stay to reduce anxiety, they had also limited the amount of different staff that would attend to the family.

A team of specialist midwives were appointed to support women who were identified as vulnerable, such as experiencing domestic violence. The team received additional training in substance misuse, neglect and mental health and would provide continuity of carer to women referred to the team. The vulnerabilities team were rolling out a day of safeguarding training in collaboration with domestic abuse services.

Maternity

Women were provided with three choices of places to birth in line with national guidance. The service offered all women the opportunity to birth at home, in the midwifery led unit, or in hospital with multi-disciplinary team input for patients with potential complex pregnancies requiring consultant led care.

Women were given a choice of food and drink to meet their cultural and religious preferences. Staff told us that cultural preferences, such as eating halal meat, and dietary information, such as allergies, were assessed and food was prepared in accordance and clearly labelled. This information was available on handover sheets to ensure staff were aware of people's dietary information.

However, women were seen by multiple staff throughout their pregnancy, labour and postnatal period due to challenges in midwifery staffing. A woman we spoke with told us they had seen three community midwives throughout their pregnancy, this had led to differences in fetal measurements due to different practice approaches, and therefore had led to the need for an emergency scan for assurance.

Access and flow

People could not always access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit and treat women were not always in line with national standards but there was ongoing work to improve this.

We saw wait times for women to be assessed within LWAU had significantly reduced with the introduction of Birmingham Specific Obstetric Triage System (BSOTS). Data showed that 71% of women received rapid review in under 15 minutes in the second week of implementation, this was not a standard that was recorded at the last inspection. For the same week in September 2022, 90% of women were triaged and their care prioritised within 30 minutes of their arrival.

Information provided by the service showed that between April and September 2022 there were 38 occasions where a red flag event was declared for a delay in commencing or the induction of labour (IOL) process, this was a significant improvement from 2021 where there were 273 red flag events for IOL commencement delays.

IOL data from June and September 2022 showed there were between one and four women were booked to attend labour ward for induction or augmentation per day. The average wait time for women being identified as requiring admission to labour ward to being admitted to the labour ward to commence induction was 1.47 days, however, we saw two occasions where women waited six days for their induction. This is not in line with national guidance. New practices had been implemented to prioritise labour, such as an electronic monitoring and prioritisation tool.

Induction rates remained below the national average of 34% within the three months prior to inspection; rates varied between 24.47% and 27.88%.

Staff planned women's discharge carefully to make sure women did not stay longer than they needed to. Staff told us that women were signed off as safe for midwifery led care by doctors before discharge. Paediatric reviews were completed as required and information was shared with women about safe sleeping, feeding, things to look out for in baby and things to watch out for in themselves, prior to discharge.

Jessop Wing maternity unit had not closed to admissions in the six months prior to this inspection. Managers told us that closures would take place if acuity outweighed the services capacity. In order to keep the service operational,

pressures were graded as follows: normal operational, early signs of pressure, signs of building pressure and extreme pressures, with action to take at each stage. These actions included reviewing additional staff options and escalation huddles, to transferring low risk women waiting for induction of labour to neighbouring NHS trusts and suspending the home birth service.

Process and policies were in place to monitor women who did not attend for an appointment. Hospital and patient cancellations were recorded, for example in August 2022 there were 2689 attendances to Jessops Wing, with 10.13% of cancellations being initiated by the hospital and 8.32% by the patient. However, the reasons for cancellation were not documented or analysed meaning the service did not have meaningful data to take action to reduce cancellations.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated concerns and complaints but did not always provide a response in a timely way. Lessons learned from complaints were shared with all staff.

The service clearly displayed information about how to raise a concern in patient areas.

Women, relatives and carers knew how to complain or raise concerns. We saw examples of concerns and complaints raised over the last 10 months. There had been 187 complaints raised between 01 October 2021 and 31 August 2022.

Staff understood the policy on complaints and knew how to handle them. Complaints were handled either informally or using the services complaint policy, depending on patient preference. We found that out of the 187 complaints raised, 104 were resolved informally and 83 resolved formally.

Managers investigated complaints and identified themes. We reviewed evidence showing that both formal and informal complaints were audited to identify themes and areas for improvement.

Staff did not always respond to complaints within policy timeframes. We reviewed four complaints; two complainants had not received an outcome to their complaint for over nine months and one had received repeated extension dates.

An action plan which commenced on 26 September 2022 highlighted areas for improvement, actions agreed, and resources required to achieve the actions. However, due to the infancy of the action plan, actions did not have ownership allocated, target dates or actual completion dates submitted. Eight of the 34 actions included, did not have evidence that actions had been completed, including if patients had received feedback.

Managers shared feedback from complaints with staff.

Is the service well-led?

Requires Improvement ● ↑

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

Maternity

Leadership

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

The maternity service was a tertiary service covering Sheffield, South Yorkshire and Bassetlaw (and some North East of Derbyshire). For some highly specialised services such as fetal medicine and primary pulmonary hypertension in pregnancy, the catchment population extended considerably beyond that described.

The service experienced a change in several senior posts in 2020 and 2022. The service was led by an Operations Director, interim Midwifery Director, and interim Clinical Director for Obstetrics, Gynaecology and Neonatology.

The triumvirate were supported through clear professional arrangements. The operations director and interim Midwifery Director were line managed by the clinical director and had professional reporting lines respectively to the chief operating officer and chief nurse. The interim clinical director was directly managed by the chief executive and has professional reporting responsibilities to the medical director (operations).

We were told by staff that changes to the senior management team (SMT) had been beneficial. It was stated that the SMT were more visible and approachable. Staff felt that this had improved morale and performance.

Vision and Strategy

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

The service had appointed a new senior leadership team (SLT) in the last six months. The SLT had set out a clear vision and strategy to improve maternity services at the trust.

The trust had worked with partners to establish an improvement programme for maternity services. The improvement programme had been developed using national legislation and guidance, such as meeting the requirements of the Ockenden report and savings babies lives recommendations and in response to improvement recommendations such as the last CQC report. Advice and support had been received from NHS England / Improvement maternity improvement advisors.

The triumvirate had made five commitments to its staff to achieve the improvement strategy. These included psychological safety and culture, leadership and management, clinical safety and quality, training and development and workforce and demand. The strategy included actions of how these commitments would be achieved. Staff received newsletter updates on the progress of the strategy and were asked to actively participate using various communication methods to continue to feed in to the 'long term focussed piece of improvement work.'

The trust provided evidence of a maternity vision and strategy which was locally developed with both staff and external stakeholders involved in its development.

Maternity

Culture

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

Staff told us the culture in the department had improved since the last inspection and that they felt supported by the senior leadership team. Managers had worked on their visibility, creating five pledges to staff in delivering the maternity improvement programme.

We spoke with several staff who stated the culture has improved greatly and emphasised that there had been a significant shift in culture. Staff told us that they were no longer "fearful of reprisal" and would willingly raise concerns, incidents and suggest ideas for improvement initiatives.

Staff survey results for the service had declined since the last inspection. Information from the service national medical staff survey 2021, highlighted that 50% (38% decline since 2019) of staff looked forward to going to work; 87% (decline of 5% since 2019) agreed / strongly agreed that they knew what their responsibilities were; and 63% (20% decrease since 2019) were personally pleased with the standard they were able to perform their work.

Most staff felt the service's culture was non-discriminatory. When asked, in the last 12 months had you personally experienced discrimination at work from a manager / team leader or other colleagues, the 'Jessop Wing national medical staff survey 2021' showed an 89% response rate for no discrimination. When asked, if they would feel secure in raising concerns about unsafe clinical practice, the survey showed a response rate of 74% against agree or strongly agreed.

Information from the 'Jessop Wing national nursing and midwifery staff survey 2021', highlighted that 28% (30% decline since 2019) of staff often / always looked forward to going to work; 86% (4% decline since 2019) agreed / strongly agreed they knew their responsibilities; and 44% (28% decline since 2019) were pleased with the standard they were able to perform their work.

When asked, in the last 12 months had you personally experienced discrimination at work from a manager, team leader or other colleagues, the survey 2021 showed an 84% response rate for no discrimination. When asked if they would feel secure in raising concerns about unsafe clinical practice, the survey showed a response rate of 64% against agree or strongly agree.

The service had a staff survey action plan for 2022/23 which comprised of six people promises to staff, each with development areas, measures and time scales to achieve a better staff experience.

Governance

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

During this inspection we found that the senior leadership had an improved governance and oversight of the service. Although the governance framework was in development, senior leaders had a plan for its implementation. Processes were now in place to give ward to board assurances about the quality and safety of services. Staff told us about an improved approach to governance and their contribution to quality and safety.

Maternity

Following the October 2021 inspection and the warning notice we issued, the trust developed a detailed action plan. During this inspection we saw that the trust had acted to make improvements to some but not all of the areas which were highlighted in our previous inspection report. The trust had reported delays to the delivery of the CQC action plan and we saw this was to ensure that the improvements to patient experience and safety were made in a sustainable way, which would be embedded.

The quality and safety framework matrons were accountable for governance, education, and fetal monitoring. Information of concern or improvement would be raised at the monthly directorate governance meetings which were held and chaired by the interim head of maternity (HOM). The interim HOM then escalated relevant information to the trust executive group (TEG) and with the board.

During our previous inspections we found that investigations of serious incidents took too long and risked repeated incidents. In September 2022, we saw that the investigation procedures had been streamlined although there remained a backlog of incidents to review. We found that when an incident was reported, the governance team provided a timeline and proforma, the incident was then discussed at a rapid review group. A weekly panel reviewed the appropriateness of incident harm grading. It was explained that the quality and oversight of investigations had improved, the back log of incidents were now allocated to staff to investigate in line with policy and a tracker had been implemented to ensure that incidents progressed through the identification and investigation process in a timely way. Senior leaders had increased processes to share learning with staff, such as sharing summaries of what went well or requires improvement via posters, secure social media, newsletters and safety huddles.

The service did not currently have a regular audit schedule in place to ensure consistent oversight of the safety of the service. As the service was conducting a retrospective piece of work to ensure all serious incidents had been investigated, audits were currently informed by the learning from serious incidents, for example an incident investigation had identified issues with completion of MEOWs and a current audit of MEOWS records was taking place to ensure these were completed in full and contemporaneously. However, the lack of a regular audit schedule meant the issues identified on inspection had not been identified previously. For example, regular audits of epidural wait times were not undertaken in line with best practice, IPC audits were not undertaken in line with frequency targets and medications audits, other than CD counts, were carried out on an infrequent basis by the pharmacy team of Royal Hallamshire.

The following committees took place on a monthly basis: departmental maternity quality and safety meeting which fed into the directorate governance meeting; perinatal mortality and morbidity meeting; departmental audit meeting; the clinical negligence scheme for trusts (CNST) task and finish group oversight meeting; saving babies lives meeting; TEG and the maternity oversight group (maternity improvement board).

Management of risk, issues and performance

Leaders and teams were using systems to manage performance effectively. They had begun to identify and escalate relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The senior leadership team (SLT) were taking a structured approach to addressing risk in a sustainable way to embed change and improvement with the maternity service. A focus had been given to the immediate risks identified from previous inspections. Risk assessments for women were now in place and we saw these being completed. Work had been undertaken around the induction of labour, RAG rating labour inductions and auditing wait times from decision to induce to induction taking place.

Maternity

The service had used the warning notice issued at the last inspection to make improvements to the governance within the service. The SLT showed an awareness that the service was on a journey of improvement and focussed on immediate risks with a strategy in place to develop quality and safety systems within the service.

At this inspection we identified that recommendations made by the Healthcare Safety Investigation Branch (HSIB) had been addressed, a review of 'fresh eyes' had taken place and its implementation in the service was now embedded, CTG monitoring and risk assessments and monitoring of women's health were now taking place.

Feedback received from NHSE/I's maternity improvement advisors (MIA) demonstrated a confidence in the newly appointed SLT. They described an open and transparent culture that recognised areas for improvement and a willingness to take actions to reduce risks. The service was implementing the MIA toolkit, managers had adopted a quality and safety stance to governance making this the responsibility of all staff, and the MIA had seen an improvement in incident reviewing and sharing of learning with staff, however, they did highlight that the speed of improvement was a concern.

A business continuity plan was in place and in date. The plan described the procedures used by the service to respond to unforeseen loss of critical services. The plan gave specific instruction and guidance for the maternity unit staff in the protection of labouring mothers and new-borns, in the event of an emergency.

The service now captured the full list of red flags within data, described in Safe midwifery staffing for maternity settings NICE guideline (NG4) 2015.

We saw that continued development of the electronic SitRep (Situation Report) allowed enhanced oversight of staffing, women awaiting Induction of Labour (IOL), activity and acuity in Maternity Services.

The services risk register was not reflective of the current risks and areas of focus. The SLT were aware this was an area for improvement and that the current risk register was not an accurate reflection of the service. The risk register was a mix of corporate and directorate risk which did not highlight priority or actions to be taken and contained risks that were not specific to the service or outdated.

Information Management

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

The service had now improved processes for women transferring to a new team. Antenatal records were now incorporated into post-natal records in one paper document which meant midwifery staff were had better oversight of risks relevant to the mother across the maternity pathway.

Following the Ockenden review, the service introduced a new benchmarking process in January 2021. Subsequent to further meetings of the senior midwifery team a bench-marking flowchart was agreed (February 2021) to ensure that a clear and transparent process was followed, regarding who was responsible for the benchmarking and contributing to the monitoring subsequent action plans.

Maternity

The service provided examples of how practice has changed following benchmarking, include HSIB report into neonatal collapse alongside skin-to-skin contact (HSIB 2020) and MBRRACE UK rapid review into SARS-CoV-2-related and associated maternal deaths. For example:

Collaboration between the multidisciplinary teams to take forward a programme of work, called 'Skin to Skin Check-in'. Its combined efforts to reduce term admissions to the neonatal unit through attention to key principles and evidences around thermoregulation, skin to skin contact and safer holding and sleeping for babies

The trust acknowledged that in the absence of an end-to-end maternity IT system they were unable to provide robust evidence for all elements of the Saving Babies Lives care bundle. A Fetal Surveillance Matron had been recruited and lead on ensuring compliance. The trust held fortnightly meetings to review actions and compliance. Board papers issued August 2022 highlighted that the trust were not meeting the standard of compliance for Saving Babies Lives.

Fresh Eyes rolling weekly Case Review Audit were undertaken. There was a rolling weekly review of 10 CTG cases to benchmark against NICE guidance, July data showed 82% compliance in Fresh Eyes review which was an increase from 15% from 2021 audit. All cases reviewed were categorised and escalated appropriately.

We reviewed NRLS between October 2021 and August 2022 and found that incident report times were variable and not always timely. Out of 2,374 incidents there were 451 reported 90+ days after the incident occurred. This means that investigations and lessons learned remained untimely.

Engagement

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

Women could give feedback about the service directly by raising concerns, complaints and compliments. They were also able to offer feedback through friends and family test (FFT) surveys and maternity services social media pages.

The service had been working with the Maternity Voices partnership with regular meetings and communications via social media to engage with the local community and enable co-production of Sheffield maternity services.

The service was part of the local maternity and neonatal system (LMNS). The Local Maternity and Neonatal System (LMNS) is a partnership of organisations, women and their families working together to deliver improvements in local maternity services.

Staff told us that engagement and communication had improved within Jessop Wing. Staff were engaged with in the following ways:

- Directorate learning forums via MS Teams with presentations provided on rotation from obstetricians and midwives;
- open questions and answer sessions were held with individual staff groups via an online platform chaired by the Midwifery Director and senior team;
- Newsletters were shared with staff and circulated via email or social media and displayed in all office areas on innovation boards.
- Nursing and midwifery matters meetings were chaired by chief nurse and deputy chief nurse via an online platform.

- Schwartz Rounds (Schwartz Rounds are conversations with staff about the emotional impact of their work) were held virtually for the Jessop Wing.

A closed social media page was available to staff which provided mental health support, shared learning, availability of additional shifts, fetal monitoring compliance, audit outcomes, successes and feedback Friday.

A refreshed maternity safety champions programme for Jessop Wing including terms of reference (ToR) and a bi-monthly agenda for face to face meetings had been implemented. Monthly safety champion engagement meetings/walk rounds were organised for the coming twelve months. An infographic including the photos of all safety champions, detailing the safety champion roles and responsibilities were on display in all maternity clinical areas. The agenda for the maternity safety champion bimonthly meetings will included:

- Review and summary of published national reports. Providing assurance that all actions required locally are being monitored and completed in the required timescales
- Review of any inspection reports and feedback from women and their families
- Discussion and analysis of the quarterly Yorkshire and Humber Maternity Dashboard and review a benchmarked position
- A report by exception of any local patient safety concerns
- To receive and discuss any themes identified from internal sources around mortality and quality improvement
- To report on progress against the Maternity Incentive Scheme (CNST)
- Report on progress against Ockenden 7 IEA's
- To report on progress with achieving aims of the Maternity & Neonatal Transformation and LMNS improvement programmes.

Learning, continuous improvement and innovation

All staff were committed to the service's journey to continually learn and improve services.

During this inspection we found that the service had implemented the following actions following our previous inspection:

- Reviewed the maternity escalation divert and closure policy
- Implemented the maternity improvement strategy
- Trained staff in PROMPT and fetal monitoring
- Staffing levels were reviewed, and further recruitment was in place
- Work had commenced in triage and IOL with waiting times audits taking place

Staff were encouraged to be part of multidisciplinary working groups to take ownership in improving areas of maternity services such as governance. Staff and leaders told us that staff were now encouraged to work more autonomously and empowered to suggest and implement initiatives for improvement, for example a newly appointed matron had focussed on the BSOT implementation in the labour ward.

Maternity

The service displayed ward information was displayed outside each ward on a Quality board. This gave key and candid information about the ward's performance, such as patient safety message of the month, improvement initiatives, IPC, risks and learning from incidents, to staff, patients and visitors.

Staff received learning specific to their ward on notice boards which captured learning after significant events and safety reminders, for example the labour ward learning included fresh eyes learning and reminders about placental histology.

The service continued to implement the Tommy's national centre for maternity improvement application prior to its national roll out in 2024. Staff had found the tool beneficial and were becoming familiar with encouraging women use the technology. The tool offered personalised care for women and enabled greater continuity of care information throughout pregnancy and provide clinical decision support to health care professionals.