Portsmouth Hospitals University NHS Trust

Inspection report

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Ratings

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

Our findings

Our reports

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

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

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

Overall summary

What we found

Overall trust

We carried out this announced well led and unannounced core service inspection of Portsmouth Hospitals University NHS Trust acute services provided by this trust because we had concerns about the quality of services. We also inspected the well-led key question for the trust overall.

We inspected two core services within the acute trust, Urgent and Emergency Care and Medical Care as well as Well Led (the trust's leadership). We inspected due to ongoing concerns regarding wait times in the trust's emergency department and flow throughout the trust.

Our rating of services stayed the same. We rated them as good because:

We rated effective, caring, responsive and well-led as good, and safe as requires improvement.

We rated one of the trust's nine services as good and one as requires improvement. In rating the trust, we took into account the current ratings of the seven services not inspected this time.

- The trust generally had enough staff to care for patients and keep them safe. The service controlled infection risk well. Staff assessed risks to patients acted on them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The trust planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.

Our findings

- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued and were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities and were committed to improving services continually.

However,

- The provider did not always ensure mandatory training was completed. In particular the trust did not meet its targets for mandatory life support or safeguarding training for all staff.
- Not all medicines and fluids were stored in accordance with guidance.
- The service was not always able to provide care in a way that met the needs of local people and the communities served. People were not always able to access care and treatment in a timely way and in the right setting.
- Responses to complaints were not completed in a timely way and did not always identify learning opportunities.

How we carried out the inspection

We looked at **27** care records, **10** prescription charts. We spoke to **19** patients and **113** staff members across the service. This included staff nurses, senior nurses, junior doctors, consultants, healthcare assistant, matrons, clinical service managers and senior leadership team members. We visited all areas of the medical and urgent and emergency core services, attended operational meetings and also reviewed environment and, equipment across the core services.

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

Outstanding practice

Outstanding practice - Trust wide

- The trust maintained a focus on improvement and its 'reset' during the COVID period.
- Individuals at all levels demonstrated pride in the organisation.
- Triumvirates played an important leadership role and demonstrated an understanding of the agenda, organisational focus, good leadership and a sense of purpose.
- The trust had obtained university trust status and had a strong programme of research.
- The trust has a clinical director for finance.
- The trust had implemented working day one financial reporting with good accuracy.
- The executive team communicated financial information in a clear way to support good financial understanding within the divisions.

Outstanding practice - Urgent and Emergency Care

Our findings

- The trust IT department had worked with ED staff and the local ambulance trust to develop an automated solution to transfer ambulance crew handover information directly into the trust electronic patient record. The solution had received a nomination for a national healthcare award. This meant clinicians had access to time-critical patient information when they needed it in the ED.

Areas for improvement

Musts - Urgent and Emergency Care

- The trust must ensure that staff compliance with mandatory training meets the trust target. (Regulation 12)

Shoulds - Trust wide

- The trust should ensure that it has a system to respond to complaints within internal timeframes and take learning from complaints. (Regulation 16)
- The trust should ensure it is meeting accessible information standard requirements. (Regulation 17)
- The trust should consider how it can improve its signposting.
- The trust should consider how it will meet its targets for black and minority ethnic representation at the highest bands in light of falling behind it's trajectory targets.

Shoulds - Urgent and Emergency Care

- The trust should ensure that the mental health assessment room is fully risk assessed and any improvements required completed to ensure patient safety. (Regulation 12)
- The trust should ensure that emergency equipment, including resuscitation trolleys and transfer bags, are checked and fit for purpose in accordance with trust policy. (Regulation 12)
- The trust should ensure that medicines and fluids are stored safely and in accordance with trust policy. (Regulation 12)
- The trust should ensure that they take action to reduce the number of patients accommodated in escalation spaces. (Regulation 12)
- The trust should ensure that completion of staff appraisals meets the trust target. (Regulation 18)
- The trust should ensure the practice of unlocked computers and open notes trolleys in the department does not pose a risk to patient confidentiality. (Regulation 17)
- The trust should ensure that all areas of the department can be cleaned effectively. (Regulation 12)
- The trust should ensure complaints are responded to in accordance with timelines as defined within trust policy. (Regulation 16)

Shoulds - Medical care

- The service should ensure staff lock patient notes trollies when not in use. (Regulation 17)
- The service should ensure that sepsis monitoring and audits are completed and recorded according to trust policy and national guidance. (Regulation 12)

Our findings

- The service should ensure sharps bins are not overfilled and that the temporary lids are used in line with internal policies. (Regulation 12)
- The service should ensure temperature monitoring and control of all areas where medicines are stored, in line with national guidance. (Regulation 17)
- The service should ensure signage and maps, both on site and on the website, are accurate and reflect the reality on site. (Regulation 17)
- The service should ensure it utilises consistently the system in place to minimise night-time bed transfers of patients on medical care wards. (Regulation 12)
- The service should consider improved reporting and mitigation of same sex breaches on medical wards.
- The service should consider improved response timescales for complaints.

Is this organisation well-led?

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

Leadership

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

Senior leaders had the skills, knowledge, experience and integrity that they needed to run the service. The trust's board included ten non-executive board members (including the chair) and nine executive members (five voting members). The executive team was generally stable and worked together to fill the board's role. Two Executive Directors were on secondment to other NHS organization's with the roles fulfilled on an interim basis. The Deputy Chief Executive had undertaken the Chief Executive role since March 2021. The role of Director of Governance was not filled at the time of the inspection. The duties of that role were undertaken by the Director of Communications and Engagement and the Chief Nurse.

The board's non-executive directors came from a variety of backgrounds including clinical and non-clinical roles in health, business, law, the military and the local university.

Each board member went through a rigorous recruitment process to verify they had the skills, knowledge and experience for the role. The trust completed a fit and proper person review for each recruit which included the required fit and proper person checks such as interviews, references and background checks. Each checklist was reviewed, dated and signed by the chair. The trust had a system to perform a fit and proper review and separate appraisal annually for each senior leader. We saw five files which showed there was an annual appraisal and fit and proper person review for each senior leader who had been in the trust for more than one year.

Each division in the hospital was led by a triumvirate including a medical, nursing and operational leader who had dedicated support from human resources, finance, analytics and digital business partners. The triumvirates played an

important leadership role, they supported the leadership team in bringing the perspective from the clinical frontline, acting as a conduit from ward to board and played a critical role in governance, risk management, vision and strategy. Members of the triumvirate demonstrated an understanding of the agenda, organisational focus, good leadership and a sense of purpose.

Leaders at the senior and directorate level understood and managed the priorities and issues the services faced. Senior leaders identified and addressed priorities in their hospitals and in recent years had worked with the system to address system wide priorities. At the directorate level leaders demonstrated an understanding of the clinical, non-clinical and financial challenges which impacted their directorates and how they fit into the trust's risks, strategy and priorities. Trust leaders worked with internal and external stakeholders to identify and address priorities.

Leadership were visible and approachable in the service for patients and staff. Trust leaders described how they aimed to be a visible, collective team, acting together rather than as individuals. We spoke with staff across two core services within Queen Alexandra Hospital most of whom said the trust leadership was visible. Many staff told us about leaders visiting their clinical areas, although some staff members told us they had not seen senior leaders on their shifts. The executive team described visiting staff in their clinical areas. Non-executive directors had not been able to visit the sites for most of 2020 and 2021 but described visiting staff on site, following the end of most COVID restrictions within the hospital.

They supported staff to develop their skills and take on more senior roles. The trust had an executive development plan based on leading for improvement. There was a development program which had begun at the executive level followed by a role out to lower bands. As part of this program the team had developed succession plans.

Black and minority ethnic representation was heavily weighted to lower staff bands but had increased in some higher non-clinical bands. The 2021 data showed that 21.2% of the organisation's workforce was from a black and minority ethnic background, which was a 1.6% increase since 2020. Black and minority ethnic representation was heavily weighted towards clinical roles and lower bands with the highest percentage of representation reflected in 44% of band 5 clinical staff. Changes to the black and minority ethnic representation since the 2020 WRES report were limited except at the band 7 non-clinical level where representation more than doubled from 3% to 8% (reflecting an increase of four people) and the very senior non clinical manager level where representation doubled from 8% to 16% (reflecting an increase of two people).

The staff survey results, which were discussed in the May 2022 board meeting, reflected the staff generally felt their immediate managers showed compassionate leadership. The trust survey results were slightly better than the national average in areas relating to compassionate leadership.

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 a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The trust's current strategy called *'Working Together',* was a five year strategy launched in 2018. The '*Working Together*' strategy had measurable ambitions against which the trust was monitoring and measuring progress. As part of the organisational reset, the trust had identified those areas that would enable the most progress to be made towards delivering its strategic aims.

Our findings

Leaders described plans to commence engagement around the refresh of the trust's five-year strategy. The reset programme had commenced in April 2022.

The strategy was structured around five aims, 'fulfil our role for the communities we serve', 'support safe high quality patient focused care', 'take responsibility for the delivery of care now and in the future', 'invest in the capability of our people to deliver on our vision', 'build the foundations on which our team can best deliver care'.

The trust's strategy provided a continuous thread evidenced throughout the well led inspection. Trust leaders demonstrated during interviews that the strategy guided them in strategic and operational decisions. This was reflected from ward to board, for instance, at committee and board meetings members discussed how projects or discussions fit into the strategic objectives. The board report template had a section requiring the writer to note which corporate objectives a board report related to. In the reports associated with the May 2022 executive board meeting the objectives section was completed and accurately reflected the relevance to each report.

The trust had programs and structures to deliver on the trust strategy. It had enabling strategies to support implementation of the strategy across all areas of the trust including: Digital Strategy, Commercial Strategy, Workforce and Organisational Development Strategy, Communications and Engagement Strategy, Estates Strategy, Financial Improvement Strategy, Governance Strategy, Nursing and Midwifery Strategy and specific strategies for the renal, cancer and imaging services.

The trust had implemented a 2022 Organisational Reset as a response to the experience of managing COVID response since 2020 and to focus on the 'new normal' going forward. This program included several initiatives, for instance, a focus on values, 'True north objectives', #ProudToBePHU and frontline focus. Leaders also explained that this would be the foundation for the consultation process for the next strategy.

The trust had recently developed 'true north' aims, as reflected in the integrated performance report board papers and discussion. True north aims were aligned to the strategic objectives and supported by specific metrics and breakthrough objectives. The breakthrough objectives were informed by the strategy, staff feedback and COVID learning; they focused on six front line areas of improvement that were expected to have a high impact on patient care and experience. The trust recognised that all were important and some reflected a focus on fundamental measures such as reducing the numbers of pressure ulcers and ensuring appraisals were completed.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. The 2018 strategy was written to align with local plans. Additionally, enabling strategies aligned with regional and national strategies. For instance, the new nursing and midwifery strategy considered how the trust could link with the national nursing and midwifery strategy.

The trust contributed to the wider health economy. The board demonstrated a commitment to working with the system and helping to develop the integrated care system (ICS) going forward and trust leaders took various leadership roles in the ICS. The board had a balanced and considered approach to support and work with of its neighbouring trusts.

Leaders and staff understood and knew how to apply them and monitor progress. The overall strategy was supported by enabling strategies. Each of these strategies was owned by a committee and the committees were responsible for monitoring progression and reporting to the board.

Our findings

Portsmouth had a history of financial deficits until achieving a small surplus in 2019/20. During 2020/21 and 2021/22 the national financial framework was revised in response to the Covid-19 pandemic with prospective and retrospective block adjustments replacing previous regimes. The Trust delivered the planned breakeven financial position in 2021/22, reporting a modest surplus of £205k (unaudited as at 26 May 2022) for the year ended 31st March 2022, representing the third consecutive year in which the Trust reported a balanced financial position and 'lived within its means'.

The Trust evidenced a mature approach to the annual planning process with clear alignment between workforce, financial and operational plans, and the Trust plan for 2022/23 was agreed with the Hampshire and Isle of Wight system. Due to remaining financial risk within the plan, delivery of the Cost Improvement Programme (CIP) will be crucial. The Trust articulated clear plans in place to oversee delivery against the plan with key metrics in place to track progress.

Culture

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

Staff felt respected, supported and valued. The trust had implemented a #ProudToBePHU program, publicised across trust sites and on-line, to engender pride in the organisation and improve staff experience, professionalism and leadership. Most individuals we spoke to during the inspection demonstrated a pride in the trust. The core service inspections identified a focus on making staff feel respected, valued and supported while delivering quality care to the patients. Staff told us they felt valued and supported by their immediate managers, spoke highly of their jobs and benefited from teamwork and peer support.

However, the 2021 staff survey reflected a drop in staff morale and engagement, which was in line with national trends. The trust implemented a package to address declining staff morale and engagement through a program of recruitment and retention, engagement sessions and a wellbeing program focusing on physical, psychological and financial wellbeing. The board had begun monitoring the impact of these measure through workforce statistics, including some information about health and wellbeing which were included in the board integrated performance report.

Staff and leaders from ward to board were focused on the needs of patients receiving care. This was underlined by the trust's values, 'Working together for patients with compassion as on team always improving' and was part of the trust's strategic aim 2, 'Support safe, high-quality patient focused care' being delivered through the 'Delivering Excellence' systematic improvement approach. Staff reported a positive and improved culture, promoting staff and patient engagement and multidisciplinary working to provide the good care and treatment to patients. The staff survey reflected that a higher percentage of staff than the national average believed service users were the organisation's top priority.

The focus on care was supported at board level by executive and non-executive board members who demonstrated a drive to put patients at the centre of care provision. Board committees were structured to ensure the quality of care was not secondary to performance by putting quality and performance oversight under the same committee. Committee members reported that combining quality and performance worked because they were directly related and one could not be discussed without consideration of the other.

Minutes and observations reflect that care and the impact of high level decisions on care were thoroughly discussed at board and committee meetings and as part of business cases. Each board meeting included a patient or staff member story which focused on patient experience and learning from both positive and negative events.

Our findings

However, as noted on previous inspections, the hospital was not well signposted and we observed patients regularly becoming lost and confused while trying to navigate the hospital.

There were mechanisms for providing all staff at every level with the development they needed, including high-quality appraisal and career development conversations. However, we found that some staff had completed appraisal paperwork but not completed meaningful appraisal conversations with their managers. The trust was aware that completion of appraisals was an area for improvement and one aim of the front line improvement focus was, 'At least 85% of staff to have an annual appraisal with their line manager'.

The service promoted equality and diversity in daily work, and provided opportunities for career development.

There was a demonstrable commitment to equality, diversity and inclusion with efforts focused both within the trust and toward the wider regional population. The trust employed black and minority ethnic staff at a higher rate (21.1%) than represented in the local community. This, in part, reflected the trust's successful overseas recruitment program in recent years. Black and minority ethnic representation was heavily weighted to lower staff bands but had increased in some higher non-clinical bands and there was a significant increase at the non-executive board level since our last inspection.

The trust aimed to increase black and minority ethnic representation at higher bands, from Band 7 to the Very Senior Manager level, to 20% by 2025. However, in March 2022 the black and minority ethnic representation at the higher level was 7.9%, thus the trust was 2.3% lower than the target trajectory of 10.2% to meet its 2025 goal.

The trust's WRES data reflected that there had been improvements in the likelihood of black and minority ethnic staff being appointed, a reduced percentage of black and minority ethnic staff entering a formal disciplinary process and discrimination from managers and colleagues. However, black and minority ethnic staff were still more likely to receive abuse from the public, were less likely to feel they have equal opportunities for promotion and still had a poorer work experience overall then their white colleagues.

The trust had developed a focus on equality, diversity and inclusion in recent years. In 2021 the trust appointed a full time equality, diversity and inclusion (ED&I) lead who was managed by the deputy chief people officer and increased the team from one to five staff members. The trust's focus moved from a concentration on staff experience to a more holistic view of ED&I as it applied to staff, patients and the community. The team engaged internally and externally with people from a range of communities and with a wide range of protected characteristics to identify and start to address inequities.

Some recent initiatives included a deaf awareness campaign, ED&I training for staff and for leaders at a board development day, a cultural intelligence program and involvement in designing the new urgent and emergency pathways and environments. The team also worked with the integrated care system, other regional trusts and public health Portsmouth to promote equality diversity and inclusion across the region.

They trust developed an Equality, Diversity and Inclusion Strategy based on the 'Every Voice Matters' report. The strategy highlighted how ED&I fit with the trust vision, strategy and values, and reflected the need to focus on three areas: workforce, community and health inequalities. The three associated strategic objectives address all three of these areas, although the principles for inclusion and measures of progress were heavily weighted toward workforce.

Our findings

The trust also offered 'Beyond Boundaries Positive Action Program', a management training program for staff members from BME backgrounds to support personal and professional development towards progression. The trust integrated performance report reflected two cohorts had completed the training and the fifth cohort was due to start in May 2022.

The service had an open culture where patients, their families and staff could raise concerns without fear. Discussions with patients and staff reflected that there was an open culture where patients, their families and staff felt comfortable raising concerns and that there were a variety of paths for people to do so.

The trust had a Freedom to Speak Up Guardian (guardian) whose role was supported by the board. The guardian had formal monthly meetings with the executive Freedom to Speak Up Lead, who was the director of communications, and formal quarterly meetings with the chief executive. The guardian supported a network of 11 Freedom to speak Up Advocates (advocates). This was a decrease from our last inspection when the guardian met with executives monthly and had 20 advocates, but the guardian was still supported. Staff demonstrated that they understood the duty of candour (the duty to tell patients or their family when something goes wrong) and a review of complaint and incident files reflected that the trust met duty of candour requirements.

However, the trust was not meeting its targets with regard to complaints and did not always learn from those complaints. In the year from April 2021 to May 2022 the trust received 343 complaints, it had responded to 288 complaints and had 55 outstanding complaints at the end of May 2022. Approximately 65% of the closed complaints across the trust had not been responded to within the trust target of 25 days and the number of breaches had been increasing since August 2021. Additionally, our review of ten complaints reflected that when complaints were reviewed, the trust missed some opportunities for learning and improvement.

Governance

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

Leaders operated effective governance processes, throughout the service and with partner organisations. The trust did not currently have a Director of Governance, due to challenges around covering the role during the post holder's secondment to another trust. However, the executive team was mitigating the impact of this gap with an established governance framework, short-term executive level ownership of the portfolio by two other executives and prioritisation of plans to ensure the role did not remain vacant longer than necessary.

All levels of governance and management functioned effectively and interacted with each other. The board had a committee system which ensured the appropriate issues, information and concerns were escalated to the board. There were five committees that report to the board: quality and performance, remuneration, finance and infrastructure, workforce and organisational development and audit. Ten subcommittees fed into the quality and performance committee, seven sub-committees fed into the finance and infrastructure committee and two fed into the workforce committee. These subcommittees were established to provide oversight of management activities, compliance and reviews. While this was an increase in the total number of sub-committees since the last inspection, committee members reported feeling the sub-committees provided an efficient method of managing the committee workload.

The committees each had executive and non-executive members and a non-executive chair. We observed that committee meetings, which were conducted on-line, were well attended. There was a clear agenda which the chair followed. We observed detailed conversations in committee meetings where both executive and nonexecutive members engaged in discussion and there were significant levels of challenge.

Our findings

Additionally, there were divisional accountability and performance meetings for each of the four divisions which fed into sub-committees and committees. Each division was led by a triumvirate including a medical director, nurse director and ops director supported by human resources and finance partners who were embedded in the team. The triumvirates worked to ensure appropriate governance within the division and escalation to the board. The divisions held separate monthly governance and performance meetings that were escalated to sub-committees and kept their own risk registers so that the triumvirate had oversight of the care groups.

The trust had raised its level of engagement and leadership within the Hampshire and Isle of Wight system. It had partnerships and relationships with the regions integrated care system where some of the trust's executives held leadership roles, additionally they engaged with three local CCGs, the city and county council, NHSI/E, system provider partners, the local university and Healthwatch.

Despite the system wide engagement the trust continued to face challenges that were intertwined with entire system for instance, regarding care for mental health patients, particularly children and young people, and flow into and out of the trust.

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.

Executives and non-executives understood their own job roles as well as responsibilities and accountabilities as individuals and as a board. Executive and non-executive directors had clearly defined roles and responsibilities but also understood their joint accountability and offered challenge and support, within and outside of their expertise, as a unitary board.

Approximately ninety trust leaders had taken part in a development programme aligned to the trust's culture change program. This programme was rolled out from the more senior to less senior leaders and managers to help develop compassionate and inclusive leadership and support the delivery of the trust's strategy.

Staff at all levels understood their own roles which was an improvement from past inspections where this was not the case. However the staff survey reflected that staff did not always feel their colleagues understood each other's job roles; the results for this question were slightly worse than the national average.

Departmental and divisional monthly meetings took place at all levels to discuss key risk and performance issues and give the opportunity to learn from service performance. Meeting minutes showed the meeting followed an agenda and was clearly recorded.

The Trust had an established clinical director of finance who sat on the finance and investment committee, capital priorities group and the business case review committee providing advice and assurance to the chief financial officer, chief nurse and medical director on financial matters that impact patient care. The clinical director of finance was recognised by the Healthcare Financial Management Association as Clinician of the Year in 2021.

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.

Our findings

Leaders and teams used systems to manage performance effectively. Staff at all levels recognised their responsibility for risk and incident reporting and used an incident reporting system to do report risks. Divisional risks were put on the four divisional risk registers and those divisional risks rated 15 or higher, as well as corporate and organisational risks were placed on the corporate risk register.

The trust had an incident review process which included a weekly incident review panel of all incidents with potential significant learning, as well as those causing harm. The panel was chaired by the medical director or their deputy.

The integrated performance report included a section on patient safety events, serious incidents and never events, this included monthly updates on pressure ulcers and falls.

They identified and escalated relevant risks and issues and identified actions to reduce their impact. The trust used a corporate risk register and Board Assurance Framework (BAF) as the structure to identify, understand, monitor and address current and future risks. The BAF was a living document which was regularly reviewed and referred to throughout board meetings, minutes and reports it reflected risks which we observed discussed at board and during leadership interviews. The last set board meeting agenda item, prior any other business, was the discuss whether any changes should be made to the BAF or risk resisters in light of matters discussed at the meeting.

The BAF reflected the risks to the initiatives in the strategic plan and the board used it as a tool to maintain oversight of those risks. There were eight risks on the BAF all rated as a high or very high risk. The summary identified each risk, the associated strategic aim, responsible executive lead and assurance committee(s) and risk score at a glance. The framework included further detail outlining possible impacts, controls, assurances reported to the board and committees, gaps, actions, mitigations and current performance.

Quality metrics were reported to the board through committee reports and the integrated performance report (IPR). The IPR included data relating to a wide range of clinical and operational metrics. Some examples include; information on quality of care measures, patient safety events, health care associated infections, patient harms, the deteriorating patient, mental health, safeguarding, cancer and stroke metrics, A&E metrics, finance, etc.

The May 2022 IPR reflected patient harms, including pressure ulcers, falls and medication incidents increasing within the trust. The IPR reflected actions taken and the increased harms were discussed at the May board meeting, so this was an issue that the board were sited on and executive leadership team were working to address, but it was not resolved. Additionally it reflected that urgent and emergency care wait times and flow continue to be a challenge for the trust.

They had plans to cope with unexpected events. The trust had a major incident response plan (not to be declared due to capacity issues) and a critical incident SOP outlining processes, individual responsibilities and information cascades.

The trust worked closely with system partners to address risks. The Trust had managed one major incident, and two internal critical incidents with system wide coordinated responses. During the recent system wide incident the trust saw a large influx of demand on services. They worked with the system to divert ambulances for a short period and military partners provided critical support to manage discharge and flow. As a result, senior leaders reported they would apply some lessons learned from system partners to future incidents. The Trust had followed de-brief and learning processes from all three incidents.

Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Our findings

Board meeting observations and minutes reflected that board members considered the quality of care when considering implementing changes to increase efficiency. Staff and leaders we spoke to reported that they were not aware of financial decisions that did not consider the quality of care.

Staff members had the opportunity to feed into the trust's cost improvement plans which require a trust identify cost saving measures. Staff were invited to submit ideas for the yearly cost improvement program based on experience in their own area, to identify ways that the trust could improve efficiency identified by people providing care and services. For instance a pharmacist had submitted a cost improvement idea around pharmaceuticals which was then submitted to the CIP process and agreed.

Information Management

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

The trust had a digital strategy (2019-2024) which aimed to improve IT systems and bring systems together. Although the strategy was in its third year, these aims continued to be relevant and the trust was working to build systems across the integrated care system and to streamline digital systems.

The trust collected reliable data and analysed it. The board used an integrated performance report to gain a holistic understanding and overview of the trust's performance. It provided an overview of key safety and organisational indicators regarding performance, workforce and organisational development, finance, quality and outcomes. It outlined indicators of actual performance, drivers of performance and balancing measures to capture the performance against risks, clarify what was driving performance and maintain holistic oversight.

The integrated performance report was updated for each board meeting. The board used this tool as a structure for discussion reviewing each area of the integrated performance report in line with the committee reports, executive reports and other elements of the agenda. We observed the board using the data and information to offer challenge and assessing which data they included.

Quality and sustainability both received sufficient coverage in relevant meetings and papers at all levels. Quality and sustainability were included in Working Together the trust's current strategy launched in 2018. Throughout committee and board meetings we observed discussions balancing quality, sustainability and performance.

There were clear and robust service performance measures, which were reported and monitored. Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care. Key performance indicator dashboards and assessments were held for each division.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

All staff had access to an electronic records system that they could all update. This included digitalising the nursing assessment processes and making this information more easily accessible for returning patients. The trust was currently working to implement an electronic prescribing system to make prescribing and administering medications safer and more efficient.

Our findings

The information technology systems were used to manage patient flow through the hospital with a real time display providing up to date information in the emergency department and available to all senior leaders.

The executive team communicated financial information in a clear way to support good financial understanding and decision making within the divisions.

The information systems were integrated and secure. The digital strategy was overseen by the IT Committee (chaired by Director of Strategy & Performance), reporting into Finance & Infrastructure Committee. The trust had recently launched a cyber security strategy which was overseen as part of this structure. As part of this structure the trust was implementing enhanced cyber defence and was running a cyber security awareness program.

Data or notifications were consistently submitted to external organisations as required. The trust had on open culture of sharing information and submitted notifications as required. With regard to financial reporting, the trust had implemented working day one reporting with good accuracy.

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.

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. During the pandemic period of the past two years the trust increased engagement with staff but limited outreach to the public. It was working to renew its community engagement.

The communication and engagement team was led by a board level director of communications and engagement. The team was fully staffed and had expanded in the past year. At the time of inspection they were drafting a communications and engagement strategy (2022-2025) to present at the July 2022 board meeting. There were a range of staff members feeding into the new strategy and the trust had completed a communications audit in 2021, responded to by between 400 and 500 staff members, which was informing the strategy.

Leaders engaged with staff in a number of ways. There were team and directorate meetings, a weekly Friday message from the CEO and a communication trust briefing. There was a monthly all staff briefing led by executives and divisional directors using an online platform so that the briefing was available for all staff.

The organisation used a closed social media page to communicate directly with staff and was also present on a range of social media sites to engage with staff and the community. They were working to implement real time digital feedback for patients and staff.

Listening to and engaging with staff members was a focus of the trust's 2022 Organisational Reset program. As part of the reset there was a focus on meaningful appraisals and a target of completing 85% of appraisals across the trust. Staff engagement events began in April 2022 with all staff and were due to continue.

The trust had a patient collaborative forum that met quarterly. The forum had recently provided feedback regarding the trusts new discharge communications. However, patient engagement was limited and the trust was focussing on how to ensure they included patient consultation more widely.

Our findings

The trust was working to increase communications and engagement with the patients and the local community to plan, improve and manage services. For instance they sought patient and community engagement regarding the development of the urgent and emergency care department and the equality, diversity and inclusion strategy.

The trust's equality diversity and inclusion lead worked closely with the communications team to help reach people in a range of equity groups within the trust and in underrepresented communities. Examples of reaching out to the community included working with the local football team, religious groups, groups for the houseless and the local eastern European community.

In 2022 the provider issued a new accessible information and communication policy to provide guidance about responsibilities and processes regarding making information accessible to everyone. However, the trust was in the process of implementing the policy and recognised it was not yet ensuring information was equally available to everyone.

They collaborated with partner organisations to help improve services for patients. The communications and engagement team worked closely with the Hampshire and Isle of Wight engagement network and other healthcare providers to create joined up messaging. Leaders described how they worked with MPs, the Portsmouth City Council, Healthwatch, the local university and police to increase engagement. The recognised the important role they played in the community as both a large employer and an anchor institution.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. They used innovative quality improvement methods, although staff did not always feel able to make improvements. Leaders encouraged innovation and participation in research.

Staff were committed to continually learning and improving services. A targeted program of front line improvement focused on six areas for improvement identified to provide the most efficient improvements for patients. This included targets around discharge, patient wait times, pressure ulcer reduction, complaint waiting times, staff appraisal and recruitment.

There was a focus on improvements at the divisional level. This was evidenced in the significant changes made in the past two years to the urgent and emergency care pathways, which staff fed into. Staff described a variety of opportunities for learning at all levels, including through training, incidents, complaints and death reviews.

They had a good understanding of quality improvement but staff did not always feel able to make improvements. The staff survey reflected staff felt less able to show initiative in their roles, make suggestions for improvement or make improvements happen than the national average. One of the three themes for the trusts 2018 to 2021 culture change program was to increase the number of staff members who felt they were able to make improvements at work. It implemented innovated methods of quality improvement as part of the delivering excellence systematic improvement program.

There was a comprehensive roll out programme for the improvement training and coaching. This had been implemented for executives and divisional leaders. The trust had begun to cascade training to care groups and frontline teams. For instance, we saw examples of how the trust used rapid improvement workshops to engage with staff and quickly implement change at the ward level.

Our findings

Leaders encouraged innovation and participation in research.

The Chief Operating Officer (COO) had responsibility for rolling out the improvement approach across Divisions, Care Groups, services and front-line teams. This was aligned to the responsibility held by the COO for urgent care service transformation and the development of the new build emergency department. The Trust appointed a non-voting Executive Director of Research to the Trust board in 2020.

The trust's leadership placed a focus on research and innovation ensuring that improvement remained a focus during the pandemic period of the past two years and that learning from this period would be incorporated in innovation. This was reflected in the trust's development of the urgent care pathways and environments, completion of several relevant enabling strategies, the Delivering Excellence strategy delivery plan and the 2022 organisational 'reset' program.

The trust obtained university trust status in 2020, in part reflecting its strong focus on research. It had a research governance structure to ensure safety, challenge and oversight and its strategic research objectives aligned with other enabling strategies.

The trust funded 120 full time equivalent staff members involved in research in a diversity of roles for instance administrators, nurses, midwives and clinical fellows. In the last financial year the trust recruited over 14,000 patients to participate in 127 diverse research studies. This reflected the largest number of patients recruited for research at a large acute trust in the country. The trust completed research in a diversity of areas with a focus on research to improve care and outcomes for the trust's communities, these included urgent public health studies and studies relating to COVID-19 treatments.

Innovation was not limited to clinical and research teams. For instance, the trust had implemented a Family Liaison Officer (FLO) team of volunteers and non-clinical staff who supported inpatients to contact family and friends by video call during the pandemic when visitors were not generally allowed in the hospital. The team completed 2000 calls from September 2019 to January 2021 alone and received positive feedback from patients, family and staff.

The Finance Team was shortlisted for Finance Team of the Year at the 2021 Healthcare Financial Management Association annual awards being recognised for significant process improvements to deliver working day one reporting and was also recognised as an innovation by the OneNHSFinance Innovation forum.

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 →← Jul 2022	Good →← Jul 2022	Good →← Jul 2022	Good →← Jul 2022	Good →← Jul 2022	Good →← Jul 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
Queen Alexandra Hospital	Requires Improvement ➔➔ Jul 2022	Good ➔➔ Jul 2022	Good ➔➔ Jul 2022	Good ➔➔ Jul 2022	Good ➔➔ Jul 2022	Good ➔➔ Jul 2022
Overall trust	Requires Improvement ➔➔ Jul 2022	Good ➔➔ Jul 2022	Good ➔➔ Jul 2022	Good ➔➔ Jul 2022	Good ➔➔ Jul 2022	Good ➔➔ Jul 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 Queen Alexandra Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good ↑ Jul 2022	Good ➔➔ Jul 2022	Good ➔➔ Jul 2022	Good ➔➔ Jul 2022	Good ➔➔ Jul 2022	Good ➔➔ Jul 2022
Services for children & young people	Requires improvement Oct 2018	Good Oct 2018	Outstanding Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Critical care	Outstanding Oct 2018	Outstanding Oct 2018	Outstanding Oct 2018	Outstanding Oct 2018	Outstanding Oct 2018	Outstanding Oct 2018
End of life care	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Surgery	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020
Urgent and emergency services	Requires Improvement ➔➔ Jul 2022	Good ↑ Jul 2022	Good ↑ Jul 2022	Requires Improvement ➔➔ Jul 2022	Good ↑ Jul 2022	Requires Improvement ➔➔ Jul 2022
Diagnostic imaging	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018	Good Oct 2018
Maternity	Requires improvement Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020	Requires improvement Jan 2020	Requires improvement Jan 2020
Outpatients	Good Jan 2020	Not rated	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020
Overall	Requires Improvement ➔➔ Jul 2022	Good ➔➔ Jul 2022	Good ➔➔ Jul 2022	Good ➔➔ Jul 2022	Good ➔➔ Jul 2022	Good ➔➔ Jul 2022

Queen Alexandra Hospital

Southwick Hill Road
Cosham
Portsmouth
PO6 3LY
Tel: 02392286000
www.porthosp.nhs.uk

Description of this hospital

Urgent and emergency services and medical care services at Queen Alexandra Hospital are provided by Portsmouth University Hospitals NHS Trust.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

The emergency department is open 24 hours a day, seven days a week, with consultant-led emergency care and treatment provided to people across the city of Portsmouth and south east Hampshire. The trust was responsible for the delivery of care in the Urgent Treatment Centre (UTC) at Gosport War Memorial Hospital.

The emergency department is a recognised trauma unit. Major trauma patients are transported directly to the nearest major trauma unit. The department has a four-bay resuscitation area, with one bay designated for children. There is an additional resuscitation area, with two bays, for COVID patients – this is called the Star Suite.

There are two major treatment areas; majors A has 17 bays, majors B has 20 bays. In addition, there is a Fit-to-Sit area with 12 chairs in and an additional bay for clinical examinations.

There is a room designated for mental health practitioners to undertake mental health assessments.

The emergency department has a separate children's treatment area with its own secure waiting room. This consists of an observed play area, a high dependency cubicle, an isolation room, five majors cubicles and four minors cubicles.

At the last inspection in July 2020, the medical care core service at Queen Alexandra Hospital was not rated because that inspection was a focused, responsive inspection. Previously, medical care at Queen Alexandra Hospital had been rated as requires improvement, in August 2018.

During our inspection we visited and inspected seven wards, including the acute medical unit (AMU), and the discharge lounge.

Urgent and emergency services

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

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

Mandatory training

The service provided mandatory training in key skills. However, this did not include the highest level of life support training to all staff and the service did not make sure everyone completed it.

Nursing staff received and kept up-to-date with their mandatory training. The trust set a target of 85% for completion of all mandatory training. Records showed registered nursing staff had achieved overall 89% compliance.

Medical staff were not up-to-date with their mandatory training. Records showed the target of 85% compliance target was not met across most staff grades. The lowest rate of compliance amongst doctors was 76%.

Staff received mandatory training in safety systems, processes and practices. All emergency department (ED) staff completed basic life support (BLS), immediate or advanced life support training depending on their role.

However, compliance rates for BLS training across the trust was 69%, below the trust target of 85%. This was fed back to the trust during the inspection. The trust were aware and acknowledged training compliance had fallen below the trust target which they attributed to the effects of the COVID-19 pandemic restricting access to face-to-face sessions. The trust leadership team had prioritised training sessions to meet trust compliance.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training was provided in different formats including as part of the induction process for new starters, face to face classroom training and e-learning. Staff knew how to access mandatory training and explained how the hospital computer system would flag-up any outstanding training or updates that were required. Senior ED staff had oversight of mandatory training completion and monitored training compliance rates.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff had training on how to recognise and report abuse and they knew how to apply it. However, not all staff had received training to the required level.

The trust had adult and children safeguarding policies which were in date and reflected current legislation and guidance. These policies provided staff with guidance on how to identify abuse and the processes to follow if they needed to raise a safeguarding concern. These policies covered other elements of safeguarding such as radicalisation and female genital mutilation. There was a quick reference guide for staff which gave details of how to make safeguarding referrals.

Safeguarding was part of the staff induction and mandatory training. Staff had the appropriate level of adult and children safeguarding training for their role.

The trust set a target of 85% for completion of safeguarding training. Overall, records showed ED staff met targets of the safeguarding training modules for which they were eligible. Although, when mandatory training was broken down by role, the medical staff were 83% compliant with their safeguarding training and nursing staff 88%.

Staff told us how they would recognise and report safeguarding issues and knew who to escalate their safeguarding concerns to. The trust had two designated safeguarding leads who were the point of contact for the team.

Information on safeguarding issues was displayed throughout the department. This was visible to patients, visitors and staff. The information displayed included the types of abuse, and who to contact if abuse was suspected or seen.

All patients under 18 who presented to the ED were checked on the national database for any safeguarding or other concerns. Concerns identified were noted on the patient record for clinical staff to see. Information about when children had attended the paediatric emergency unit was shared with health professionals and relevant authorities.

Members of the trust safeguarding team visited the paediatric emergency unit every morning to offer support and supervision to the team. Staff knew how to make a multi-agency safeguarding hub referral. The multi-agency safeguarding hub brought together a team of multidisciplinary professionals from partner agencies into the same room to deal with all safeguarding concerns, where someone was concerned about the safety or wellbeing of a child.

Cleanliness, infection control and hygiene

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

We saw cleaning staff on the unit throughout our inspection and our observations showed a generally visibly clean clinical environment. Furnishings, such as chairs and flooring were wipeable and easy to clean. However, some areas such as nurse's stations and desks were cluttered and there was high and low level dust.

The department had dedicated housekeeping staff who were responsible for cleaning patient and public areas, in accordance with daily and weekly checklists. Cleaning records were up-to-date and demonstrated areas were cleaned regularly and deep cleaned when necessary. Cleaning equipment was stored securely in locked cupboards. This meant unauthorised persons could not access hazardous cleaning materials.

We saw evidence of cleaning audits in the emergency department and who was responsible if cleaning standards fell below certain levels. Managers monitored and reviewed all areas of the department each month and documented areas that needed more cleaning or repairs. This information was fed back to cleaning or maintenance staff for action.

Clinical equipment was generally visibly clean. However, some trolleys containing emergency equipment were dusty on the top, indicating they had not been cleaned. There were no stickers on equipment, detailing the date and time items were last cleaned.

Staff followed IPC principles, the trust's policies and national best practice guidelines, including the use of personal protective equipment (PPE). In addition, new protocols and procedures had been produced in response to the COVID-19 pandemic. Staff were bare below elbows for more effective hand-washing and wore surgical masks. Staff had access to PPE and wore disposable gloves when required. Staff had the facilities needed to effectively wash their hands to help prevent avoidable health acquired infections. The department was equipped with adequate hand-washing facilities and hand sanitiser gel was available throughout the department.

Managers audited staff compliance with infection control practices. The audit programme was used to maintain and improve standards and to help prevent the spread of infection. Staff compliance was reported to IPC specialists within the trust and any actions required were fed back to staff in the department.

There was a designated area for patients who presented with COVID-19 symptoms or were testing as COVID-19 positive. Staff wore PPE in line with national guidance when they entered the area. Signs were visible to prevent unauthorised people accessing the area. Confirmed COVID-19 patients are usually cared for in the area designated Majors A. To gain access to Majors A, patients had to move through Majors EDU. To mitigate risk of infection all patients were required, unless medically exempt, to wear surgical masks. Trust protocol indicated that doors in the EDU are kept closed during the transfer of a patient through the department. There was good adherence to trust IPC protocol during the inspection. However, not all doors were closed during a transfer of one COVID-19 patient through Majors EDU.

Staff had access to rapid testing facilities for patients with suspected COVID-19. Rapid testing for COVID-19 was completed for any patients suspected to have COVID-19. Point of care testing equipment in the department included glucose meters, urine testing sticks and a blood gas machine.

Environment and equipment

The design of the environment and storage of safety equipment did not always support keeping people safe. However, the general maintenance, use of facilities, available premises and equipment supported keeping people safe. Staff managed clinical waste well.

Since our last inspection in 2019 changes had been made to the emergency department to improve patient flow and the use of space. The main waiting room had improved visibility for staff to observe patients waiting prior to treatment. The ambulance handover process had been changed and patient no longer waited on trolleys in corridors.

The department was close to diagnostic imaging facilities which allowed for diagnostic procedures to be completed while waiting for a specialist review.

One room was assigned as the mental health assessment room. The room had been re-purposed from a staff well-being room during the pandemic. The room did not fully comply with best practice quality standards to provide a safe environment. The service was aware and had carried out a recent risk assessment of the room and a number of improvements had been identified. However, for safety the furniture could not be easily lifted or moved, the room had an alarm system and a door that opened both ways.

Staff carried out daily safety checks of specialist equipment. We checked four resuscitation trolleys in the emergency and children's emergency departments. Trolleys were secured with a tamper evident seal. Staff completed daily and weekly checklists for each trolley as per trust protocol. However, in the Star Suite (Red Covid) resuscitation room, the trolley checklist had not been completed fully on five occasions during April 2022.

Electrical equipment, such as defibrillators, stored on the trolley had been serviced in the last 12 months. However, on two trolleys single use suction catheters were stored in such a way that they had become damaged and not fit for use. Staff were alerted immediately, and they replaced the items. Additionally, staff took photos of the damaged item to aid learning for the department.

Urgent and emergency services

The service had transfer bags containing emergency equipment for staff to use when transferring patients to other departments. We did not open any bags, but reviewed safety checklists completed by staff. Compliance in completing the daily checks was generally consistent, however there were gaps meaning the service could not be assured all checks had been done and the equipment was safe to be used in an emergency.

Patients could reach call bells and staff responded quickly when called. Throughout the inspection we observed numerous examples of staff responding quickly to patients needing assistance.

There was an ultrasound machine available in the resuscitation room for emergency use. Equipment was stored appropriately and there was evidence it had been serviced recently.

Staff disposed of clinical waste safely. Staff correctly segregated waste into clinical and non-clinical waste. There were clinical waste bins indicating what should be disposed of in them. They also had domestic waste bins for non-clinical waste which had signs on to remind people what could and could not be put into these bins. Sharps bins checked were signed, dated and stored appropriately.

There was limited access to certain areas of both the children's and adult emergency departments with access only gained by authorised persons via a swipe card or intercom which created a secure environment.

The department had a separate viewing room for families to see their relative's body if they had passed away. The Royal College of Emergency Medicine: End of life care for adults in the emergency department 2015 recommends this as good practice.

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 completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly including after any incident. Patients arrived in the department through the main entrance or the ambulance entrance.

Patients arriving by ambulance were taken straight to the resuscitation area or assessed in the consultant-led major's area. Where appropriate, the ambulance service pre-alerted the department if a patient was on route and needed urgent medical care. This was to make sure an appropriate team was waiting for the patient on arrival.

The ambulance entrance had an ambulance control nurse who took handover of patients from ambulance staff. We observed and spoke with the clinician undertaking streaming. Streamers were band 7 or above and had undertaken further training to perform this role.

A National Early Warning Score (NEWS2) would be calculated for patients. Staff used this early warning system to monitor patients for risk of deterioration, for example, sepsis. NEWS2 is a recognised system used to detect deterioration in adult patients. It is based on six patient observations, breathing rate, amount of oxygen in the blood, blood pressure, heart rate, level of consciousness and temperature.

Paediatric patients, if not needing resuscitation, would be taken by the ambulance crew to the paediatric ED and triaged by the dedicated children's team. Paediatric patients who did require resuscitation would be taken directly to the dedicated paediatric bay in the resuscitation area, which was available 24 hours per day.

Urgent and emergency services

The main ED entrance had a streaming nurse responsible for assessing all patients for risk and for COVID-19 symptoms before streaming (directing) them to the relevant areas of the department depending on their clinical need; such as the emergency care centre, same day emergency care or majors.

Self-presenting patients, including paediatric patients, were assessed on arrival to the building by the streaming nurse. High-risk patients would be taken straight to majors A or the paediatric ED.

We observed patients being triaged in both adult and paediatric areas and found assessments to be thorough and complete. Patients, depending on clinical need, would be sent for further tests before seeing a doctor. For example, electrocardiograms, blood tests and urinalysis. This meant medical staff would already have some results when they examined patients.

Patients taken through to the main or paediatric ED were risk assessed and clinically observed using NEWS2 or the paediatric early warning score (PEWS) during their stay in the department to help staff identify unwell patients or signs of deterioration. All records we reviewed had accurately calculated NEWS2 or PEWS scores. Where required, appropriate action was taken if the score was raised.

Staff knew about and dealt with any specific risk issues, for example sepsis. There were pathways which identified a specific bundle of care to be provided including the timely administration of antibiotics. All patients were screened at the first time their observations were recorded using a screening tool.

The department had implemented the use of the ED Safety Checklist. This was a checklist used to check and record clinical tasks that needed to be completed for each patient in the first few hours of being in ED and that they had been carried out in a timely way.

The service had 24-hour access to mental health liaison and specialist mental health support. A mental health liaison team, located at the hospital but provided by a different NHS trust, was available 24 hours, seven days a week to support the care and treatment of patients with mental health illnesses. The trust also contracted security staff, who they said had relevant training in conflict management and restraint techniques, to safely support patients demonstrating challenging behaviours due to their mental health conditions.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The mental health liaison team supported staff to carry out assessments of patients. The assessment set out clear guidance about the actions staff needed to take, dependent on the presentation of the patient, to protect them from harm.

Nurse staffing

The service 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. Although matrons regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction, filling nursing shifts was a challenge.

The service experienced challenges in ensuring there were enough nursing and support staff to keep patients safe. Staff said it had been normal for there to be gaps on staff rotas daily across the emergency department and that it was a regular occurrence for staff to finish shifts late.

Matrons calculated and reviewed the number and grade of nurses and support staff needed for each shift. Managers used an online rostering system to monitor and adjust the skill mix across shifts and staff levels.

At the time of our inspection, the main ED planned 24 registered nursing staff and 10 healthcare support staff per shift, with a mix of senior and junior nurses on duty. The trust had increased the planned nurse staffing numbers over agreed establishment to help mitigate staffing and patient flow issues. The agreed establishment numbers for the department was 19 RNs and 10 HCWs.

On the day of our inspection both the main and paediatric ED were fully staffed. However, we reviewed staff rosters for the week of the inspection and the following week. This showed shifts were not always filled to the agreed levels despite actions and mitigations of managers.

Registered children's nurse staffed the paediatric ED, with always a minimum of two registered children's nurses on shift. This was in line with guidance set out in the Royal College of Paediatrics and Child Care: Facing the Future: Standards for Children in Emergency Care Settings.

Each shift had a nurse in charge (NIC) who had oversight of how the department was operating and a matron, who the NIC could escalate concerns to.

The service employed emergency nurse practitioners (ENPs) in the department, for example in streaming and triage. ENPs were qualified to assess, diagnose, treat and discharge patients with certain injuries without having to refer to a doctor.

The service had dedicated practice development nurses and a consultant nurse to provide support and education to clinical staff and to improve their professional practice. Staff were complimentary about having these roles in the team and how they had made a positive difference to performance.

To safely meet the needs of patients with mental health illness accommodated in the short stay areas of the department the service requested trust based or agency registered mental health nurses. However, these shifts were not always filled, and the emergency department nursing staff managed these patients with the support and guidance from the mental health liaison team. This included, when needed, health care assistants with some additional training to carry out one to one supervision of patients with mental health illnesses.

The department used bank and agency staff to cover gaps in the rota to make sure staffing levels kept patients safe. Bank and agency staff we spoke with said they were given a good induction to the department and the team were supportive and helpful.

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. There were 20 consultants in total, with middle grade and junior doctors covering a seven-day service. Consultant cover was provided 24 hours per day Monday to Thursday. Consultant cover was provided between 8am and midnight Friday, Saturday and Sunday, which adhered to the Royal College of Emergency Medicine recommendations of 16 hours per day. Outside of these hours a consultant was on-call and staff reported they could be contacted for support and guidance.

Urgent and emergency services

A consultant paediatrician was on site at the service until 8pm on Mondays to Fridays and from 9am to 3pm on Saturdays and Sundays, and on-call outside of these hours. The children's emergency department was staffed with middle grade doctors. Nursing staff we spoke with told us they could contact medical staff when needed to attend and review patients.

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work. The service had a good skill mix of medical staff on each shift and reviewed this regularly.

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 stored securely.

All staff could access patient records easily. Staff told us patient care plans were accessible and kept with the patients' records. The department used both paper and electronic patient records (EPR). Paper records included individualised plans of care; for example, pressure area prevention and falls care plans, observations and treatment given.

The service had developed a technical solution to automatically upload patient records from the attending ambulance crew. Clinicians in the ED could access patient notes prior to patients being offloaded from ambulances. Previously records had to be manually uploaded from the ambulance crew system to the trust systems.

The EPR was used to register patients, monitor their movement through the department and request and review investigations. The computer system also had the facility to alert staff about specific needs of patients such as those living with a learning disability or dementia.

Computer systems in the department were protected by password to prevent unauthorised persons accessing patient information. However, computers were not always locked and staff remained logged-in to the system when computers were left unattended.

Records were generally stored securely and in all secure areas. Notes trolleys were not always locked and was deemed to be less of a risk to patient safety than having the notes trolley locked. We did not see any patients notes left unattended.

We reviewed seven patient records and found the all were completed in black ink, had legible handwriting and documentation occurred at the time of review or administration of treatment.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. However, not all medicines and fluids were stored securely.

Staff followed systems and processes to prescribe and administer medicines safely. Emergency medicines were stored securely and frequent checks had been completed to ensure medicines were available and safe to use. Medicines stock lists were reviewed to ensure critical medicines would be available.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. There were no pharmacists based within the department, but they did have access to a pharmacist if needed.

Staff completed medicines records accurately and kept them up to date. There were effective arrangements for the recording of medicines administration and prescription charts showed medicines were being given as directed. Staff stored and managed all medicines and prescribing documents safely.

Staff generally checked fridge temperature were being kept within agreed limits to ensure medicines were kept at the correct temperatures. However, in the Star Suite (Red Covid) resuscitation room fridge temperature checks were missed on 16 occasions across February and March 2022. Additionally, in the Star Suite intravenous fluids not able to be locked away as the storage cupboard had no door, which was not in accordance with trust policy. A vial of an injectable solution was also left unattended in the Star Suite. Issues with safe storage of medicines and fluids in the Star Suite had been noted department governance meeting minutes from 3 February 2022.

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

FP10 prescription pads and forms were stored securely and their serial numbers were tracked throughout the department.

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.

Staff raised concerns and reported incidents and near misses in line with trust policy. The policy included definitions of incidents and their level of harm and how incidents should be reported, investigated and actions taken.

Staff told us they used an electronic system for reporting incidents and could easily access the system. Staff working in the ED said they knew what constituted as an incident and were encouraged to report incidents or near misses so that effective measures could be taken to minimise ongoing risk to people or the organisation. Staff told us there was a no-blame culture and they felt confident in reporting incidents.

The service had not reported any never events in the ED in the last 12 months. A never event is a serious incident which is wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Leaders described how the department considered each incident as a learning experience. They were proactive in reviewing incidents and making changes as a result. For example, additional staff training or a change of a working practice or procedure. Staff told us learning from incidents was shared via meetings, emails and handovers.

Post-inspection we reviewed clinical governance meeting minutes and saw evidence incidents were discussed, investigations into incidents reviewed, actions taken to reduce risk and reduce the likelihood of reoccurrence put in place and to see if there were any trends emerging.

The department held mortality and morbidity meetings to discuss patient deaths or adverse incidents affecting patients. These meetings gave an opportunity for the clinical team to review deaths as part of their professional learning and reflective practice in a safe space. Talking through patient case studies was seen as a way to improve quality of care given to patients and their families in the department.

Urgent and emergency services

Staff could explain duty of candour and understood their responsibility to be open and honest with patients and their relatives when something had gone wrong. The hospital had a duty of candour policy.

Safety learning events (SLE) were a set agenda item at the monthly patient safety and quality forum. Senior ED staff ensured actions from SLEs were acted upon where needed and information shared with staff.

Is the service effective?

Good 

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

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff had access to a wide range of up to date policies, procedures and guidance available on the service intranet which were version controlled. This enabled both adult and paediatric staff access to up to date guidance for the treatment and care of patients in the emergency setting.

Staff routinely referred to the psychological and emotional needs of patients and carers. Staff discussed patient needs at key points in their care and escalated any concerns regarding their care to the appropriate specialism.

Clinical practice reflected guidance and best practice. Key issues in patient care were handed over and acted upon. Senior clinical staff gave clear direction and support to junior staff and ensured patients received care and treatment based on national guidance.

Staff protected the rights of patients subject to the Mental Health Act 1983. The mental health liaison team supported staff to protect the rights of patients detained under the Mental Health Act.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients were regularly offered hot drinks and snacks.

Nursing staff checked which patients were not able to eat and drink, prior to serving drinks and snacks. Patients told us they were offered drinks and snacks.

Patients accommodated in the short stay areas, were offered three hot meals a day. Fresh water was available from water dispensers in all areas of the emergency department.

Urgent and emergency services

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used pictorial aids to assess the pain of patients who were not able to verbally communicate.

Staff prescribed, administered and recorded pain relief accurately. Patients received pain relief soon after it was identified they needed it, or they requested it.

Staff monitored pain level of patients and recorded the information in patient notes.

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. The service leads said local audit outcome reports for Royal College of Emergency Medicine (RCEM 2019/20) audits had been created and presented within the respective speciality. Action plans were in place to respond to RCEM 2019/20 audits.

Additional national audits included Emergency Medicine, Severe sepsis and septic shock (care in Emergency Departments), Pain in Children (Care in Emergency Departments) and Infection Control (Care in Emergency Departments). All of these were in progress and had either been reported or were due for reporting in 2022.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment. Information from audits was displayed within the ED. Managers shared and made sure staff understood information from the audits and used governance and staff meetings to discuss areas of achievement or where improvements were required.

Improvement was checked and monitored. The service had a dedicated local audit plan for the ED services. Each audit had a named owner, time scales for delivery and how learning outcomes would be shared.

The service had a lower than expected risk of re-attendance than the England average. Reattendance within seven days of previous attendance was continuously below the England average and was currently at 6.9%, compared to the England average of 10.5%.

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. Leaders allocated staff to roles within the ED based on their competencies, skills and training. Practice educators worked alongside the ED leadership team to support staff and ensure they had the right level of training and competencies for their role. This meant patients received care from staff who knew how to meet their needs.

Managers gave all new staff a full induction tailored to their role before they started work. Leaders ensured bank and agency staff received a full induction before starting their shifts in the ED. New staff entering the ED were assigned competency workbooks by practical educators. This enabled staff competencies to be monitored over time to ensure they met the required professional standards and provided patients with appropriate care and support.

Managers supported staff to develop through yearly, constructive appraisals of their work. Leaders ensured staff received regular appraisals and the service now met the required internal standards for appraisals completion for nursing and medical staff. However, leaders had recognised that staff had reduced access to learning and development during the Covid-19 pandemic and were taking action to address that.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge and ensured staff received any specialist training for their role. Leaders identified any staff who required additional training and worked with the practice educators to provide this. This provided additional experience and career opportunities for the wider staff team.

Medical staff had dedicated, regular time allocated to them for training, both individually and as a group. Staff said they would welcome additional training about meeting patients' mental health needs as they did not feel fully equipped to care for patients with mental health conditions accommodated in the department.

Multidisciplinary working

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

Throughout the inspection we saw multidisciplinary team working in all areas. Clinical staff said nurses, doctors and allied health professionals worked well together within urgent care and felt part of the team.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Medical and surgical specialities came to the department to discuss the care and treatment patients required before admission to the hospital.

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 and required urgent mental health assessment. Staff used the electronic record to flag patients who may have additional needs, for example, autism, learning disability, safeguarding concern or a frequent or returning patient. This enabled staff to effectively manage care for patients by ensuring the right teams were involved.

A mental health liaison team was based in the emergency department and available throughout the day and night. Staff referred to the team for assessments for patients as required. However, staff told us they found difficulties in finding appropriate placements for patients with mental health needs, particularly those detained under the Mental Health Act.

Seven-day services

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

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.

Urgent and emergency services

Consultant rotas were arranged so there was consultant cover in the department 24 hours a day seven days a week. Out of hours interventional radiology was available for patients who presented with an emergency.

The service recognised accessing mental health resources within the region and healthcare system was challenging. Service leaders understood the trust was not a mental health care provider. They reviewed cases where patients with mental health needs had attended the trust and had experienced significant delays in transfer to mental health care providers. They used the data to help improve services for patients and reduce waiting times.

Health Promotion

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

The service had relevant information promoting healthy lifestyles and support within the ED. The ED provided additional information on the management of health for patients who attended. Leaflets to guide patients and carers on the care of minor injuries were readily available.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff could refer patients to other services, for example diabetes support, alcohol and substance misuse, or frailty services.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff we spoke with understood the need to support patients who lacked capacity and how to apply the MCA to provide appropriate care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed staff seeking consent from patients before offering care or treatment based on all the information available.

Staff could describe and understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Staff within the children's ED understood how to apply the competencies and guidelines in their day to day role.

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 followed service risk assessments when managing patients who required additional support with their mental health needs.

Staff could describe the use of Deprivation of Liberty Safeguards. Discussion with staff demonstrated they had a good understanding about the use of Deprivation of Liberty Safeguards, and when and how they should apply for a Deprivation of Liberty Safeguard for a patient.

Urgent and emergency services

Is the service caring?

Good 

Our rating of caring improved. 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 staff treating patients with kindness and respect. Staff used privacy screens, curtains and knocked on closed doors to promote people's privacy and dignity.

The staff promoted a culture of kindness towards patients and each other and we observed positive interactions between patients and staff.

Patients said staff treated them well and with kindness. We observed a member of staff speaking gently to an elderly patient and taking additional time to explain what was happening to them and providing reassurance. We saw staff speaking with a child, being kind and explained what was going to happen to them in way the child could understand.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff providing support to patients when they were able to.

Staff told us about examples of providing support including contacting veteran charities, who would come to the ED and sit with patients who were veterans and were lonely or did not have family or friends to support them. Volunteers also helped with non-clinical roles for example helping a patient to contact their relatives or spending time with a patient who needed emotional support.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff responded in a timely way despite the workload and staffing pressures within the department.

The children's emergency department had a dedicated play therapist. They organised daily play and activities for children and supported the delivery of care for worried and anxious children.

Staff demonstrated empathy and were respectful and compassionate to families when having difficult conversations. Staff and patient were able to use the relative's room and viewing room. ED staff had designed the room and raised funds for it to be decorated and furnished.

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.

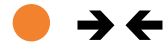
Urgent and emergency services

Staff made sure patients and those close to them understood their care and treatment. All patients we spoke to felt involved in their treatment plans and were able to ask questions. Relatives told us they felt involved and fully informed in the treatment plans of their loved ones.

Staff in the children's emergency department talked to patients in a way they could understand, using communication aids where necessary.

During the pandemic the trust restricted visitors in line with national guidance. Staff were aware patients did not always have their usual support network available to them while in the hospital. Staff were mindful of the impact this had on patients. National restriction guidance had eased at the time of the inspection and the trust were allowing limited visiting and carers to accompany patients. Patients were grateful for the lifting of these restrictions.

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 care but was not always able to provide 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 to attempt to meet the needs of the local population. Leaders worked with external stakeholders to respond to increased patient demand and meet the needs of the wider health care economy. Leaders were engaged with community health services, primary care services and other NHS organisations to adapt ED services. For example, developing and implementing the emergency care centre and same day emergency care services alongside the ED to stream patients more quickly and safely and avoid hospital admissions while reducing patient waiting times.

At the time of the inspection, many of the changes and developments made were relatively new and had not had the opportunity to realise the level of improvement anticipated. System pressures were hampering the effectiveness of the pathways and the ability of staff to provide the care they wanted to give.

Facilities and premises were generally appropriate for the services being delivered. However, increasing attendance numbers affected the suitability of the department.

The service had made improvements to the physical environment to manage increased demand and in response to the COVID-19 pandemic. The service had increased space for ambulance handovers and in the waiting room for self-presenting patients. This had significantly improved social distancing and workspace for staff. The service had agreed and funded plans to develop the ED footprint to meet the needs of the local health care economy, which it had shared with internal and external stakeholders.

There was a separate entrance for patients arriving to the department by ambulance. This provided direct access to the resus area of the department.

Urgent and emergency services

For patients self-presenting to ED, the streaming desk was located at the entrance. The streaming nurse would assess patients depending on their clinical need and assigned them to different areas of the department

The majority of self-presenting patients needed to book in at reception. The reception desk had varying heights so there was a lower desktop where patients could sit when checking in and the desk was also accessible for patients in wheelchairs. During the inspection we saw there was adequate seating for patients and other visitors in the waiting areas we reviewed.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health needs. There was an increase in patients presenting with mental health conditions. Improvements had been made since the last inspection to better support patients presenting with mental health conditions.

The service relieved pressure on other NHS services however, this put a strain on the department. We spoke with patients who said they had attended the department having struggled to get an appointment with their GP or their dental practice. Staff reported they had seen an increase in what they described as the inappropriate use of the emergency department since the COVID-19 pandemic and this put a strain on the department. Staff told us this was primarily due to patients not being able to access care in the community.

The leadership team described how they communicated with the public in an attempt to direct them to the correct services or how to self-manage at home if they did not require the services of the emergency department. The trust has launched the 'nowhere to go' campaign to signpost the community to the most appropriate urgent and emergency care. The service worked with other organisations to plan services. Leaders regularly engaged with commissioning groups and local community services to plan the urgent and emergency care system in Hampshire and the Isle of Wight.

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 said they treated every patient as an individual and made reasonable adjustments to meet the needs of patients with a learning disability, mental health issues or who were living with dementia. Staff gave us examples and we observed during the inspection how staff considered individual needs before care was given.

The ED service had processes in place to fast-track patients who self-presented with specific conditions. This included children, oncology patients and other high-risk patients. However, at the time of our inspection demand within the wider hospital meant beds were not always available in a timely manner.

Posters in the waiting areas showed patients the different areas they may be streamed to during their ED journey depending on their illness, these including seeing an ED doctor, speciality doctor or being referred for tests.

ED staff were aware of the specialist nurses in the trust. Staff said they would contact them if patients with specific needs attended the department, such as patients living with dementia or patients with a learning disability.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet their needs. Staff described how they would, where possible, provide a calmer environment for patients who had mental health needs or learning disabilities. Staff could access hot meals for those patients who had been in the department for a number of hours, or days.

The service had recruited mental health nurses, to support the department's increasing demand for mental health care and support, including patients detained under the mental health act.

We saw signs informing hearing impaired patients there was a hearing loop. This is a special type of sound system for use by people with hearing aids. The hearing loop provided a magnetic, wireless signal that was picked up by the patient's hearing aid when it was set to a certain setting. This helped reduced background noise and competing sounds that lessen clarity of sound in a public area.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Patients whose first language was not English, or those who used sign language had access to interpreting services. Staff we spoke with were aware of how to access these when required.

Access and flow

People were not always able to access care and treatment in a timely way and in the right setting.

The trust continued to struggle with the management of flow through the hospital. Leaders acknowledged this and explained it was due to a significant rise in emergency attendances and subsequent admissions particularly in medical care. At the time of our inspection average weekly trust bed occupancy was consistently over 97%, reducing the ability to move patients' away from the ED into the ward areas.

The ED service regularly looked at ways to improve the management of patient flow through the department, which included ways to improve the layout and configuration of the department and pathways through the department.

The total number of attendances to the ED during the period February 2021 to January 2022 was 145,787. This equated to a 17% increase on the same period the year before. Ambulance transports into the emergency department for the same period was 48,008, which equated to 33% of all attendances.

Data from 16 April to 24 April 2022 showed that on average 72% of ambulances were handed over within 15 minutes. The range fluctuated between 15% to 72% during this period and equated to an average of 2,096 minutes lost per day. Insufficient physical capacity in the ED was the result of a full hospital. Ambulance handover delays correlated with bed occupancy. When bed occupancy was high, space was reduced in the ED for the treatment of emergency patients.

ED managers and the trust continuously monitored treatment within agreed timeframes and national targets to demonstrate the emergency care performance, and to see if changes implemented had made improvements. However, despite these actions some patients were waiting long periods for decisions regarding their care and treatment, and decision to admit or discharge.

Following the last inspection there had been improvements particularly with the quicker and safer processing of ambulances at the front door and triage of walk in patients. The introduction of a streaming role at the ambulance entrance, to ensure better senior decision making and enabling patients to be sent directly to the emergency care centre and same day emergency care, had helped reduce handover issues.

The nurse in charge, consultant in charge and patient flow coordinator would meet hourly when the department was busy or overcrowded, to try and manage the flow. This included reviewing patients waiting for a bed in the hospital to determine if they were appropriate for same day emergency care, or alternative services.

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The nurse in charge was responsible for monitoring the triage time. When waits were long, staff could be allocated from other areas within the department. Specialist nurses, practice educators or matrons could also be called to support triage in the department. When the ambulance queue was busy, the local ambulance trust sent a 'Hospital Ambulance Liaison Officer' (HALO) to support the department.

The service ensured all patients who were waiting had actions in place including prompt review and nursing checks. However, factors such as high bed capacity, discharges, waiting for additional clinical review, or mental health referral were key factors affecting patients waiting times.

Emergency department staff could not always carry out their assessments in a timely manner. Staff found it particularly challenging during time of high attendance in the department. National guidance states that following streaming, triage should be delivered within 15 minutes of the arrival in the department. We observed triage and there was a clear process for this. Data provided by the trust showed for the 3 weeks prior to the inspection, patients wait on average 12 minutes for initial assessment. However, in the previous 10 weeks to that patients had waited on average over 15 minutes every week, the shortest average wait being 21 minutes and the longest average wait 40 minutes.

The department was moving away from the previous targets of four hour and 12-hour breaches. They were embedding new metrics which included: time to initial assessment; the number of patients spending 12 hours in the emergency department; the number of patients spending more than an hour in the emergency department after being declared clinically ready to proceed.

Staff who led the department told us about the long waits for ambulance handover, triage and waits for treatment. They described the biggest issue was poor flow out of the department. For example, at midday on day one of the inspection there were 41 patients in the ED waiting for a bed in the hospital. These were patients who had been seen and treated but could not be moved from the department to other areas and this caused a bottleneck in the department.

On the day of our inspection there were patients who could have been streamed to the same day emergency care (SDEC), therefore relieving the emergency department of some of the pressure. However, seven of the eight beds in the older persons SDEC area were being used as an escalation area for patients who required an overnight stay so this was not possible.

Managers agreed work needed to be done to ensure all pathways within the department were fully utilised to support the timely movement of patients in and out of the emergency department.

The trust identified and monitored medically fit patients across the trust who were waiting for social care provision to be discharged. Patients waiting for discharge had a negative impact on the availability of beds in the trust which in turn affected the flow of patients out of the emergency department into medical care wards. For example, on the day of the inspection there were 41 patients in the emergency department who had a decision to admit but for who there was no bed available.

There was a trust wide escalation plan in place. Staff had access to an escalation matrix and action cards which identified actions that should be taken by specific roles. The plan was used to reduce pressure within department when required, depending on the level of risk identified and pressures on the service.

Urgent and emergency services

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. However, responses to complaints were not completed in a timely way.

Patients could make complaints in various ways, verbally, by telephone and in writing by letter or email. The department clearly displayed information about how to raise a concern in patient areas. The hospital had a complaints leaflet which patients could take away and read at home. The hospital website had a detailed page explaining the complaint procedure and how to make a complaint. The complaint leaflet could also be downloaded from there.

Staff told us they always tried to address complaints or concerns as soon as possible. The team attempted to resolve any issues before concerns escalated to become formal complaints. Conflict resolution training was part of the mandatory training. If the problem could not be resolved by the team, patients would be given contact details of the Patient Advice and Liaison Service (PALS). The PALS office had a visible presence within the main entrance of the hospital. Information regarding PALS, the services they offered and how to contact them was displayed in prominent areas in ED and on the hospital website.

The trust acknowledged responses to formal complaints did not meet their agreed policy timeframes. The department had received 68 formal complaints between 1 April 2021 and 31 March 2022. The main themes were the care given, staff attitude and clinical treatment. Data showed 15 complaints were closed within policy timeframes, 45 were closed after the deadline and eight were still on-going.

Staff discussed complaints in clinical governance meetings and any complaint themes or trends were analysed and actions put in place to stop issues occurring again. The trust provided a breakdown of the complaints, with outcomes and learning resulting from the complaint.

Staff said learning from complaints and concerns would be communicated to them mainly at handovers, team meetings and through emails.

Is the service well-led?

Good 

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

Leadership

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

The trust was split into divisions with each division having a management structure and clear lines of responsibility and accountability. The emergency department (ED) was part of the medicine and urgent care division. The division was led by a triumvirate of a divisional medical director, divisional director of nursing and a divisional director of operations.

The ED had its own triumvirate: ED clinical director, ED head of nursing and ED operational manager. The department had three matrons who were responsible for the nursing aspects of the ED at the time of our inspection. The triumvirate were supported by a governance lead, audit lead and the children and young person lead.

The ED leadership team understood and could describe the challenges to quality and sustainability within the department and had pro-active on-going plans in place to address them. They were aware of the challenges to meet ED targets and had plans to improve service delivery. They were working to create better patient facilities, patient flow and increase capacity. For example, with the introduction of the emergency streaming, emergency care centre and same day emergency care model.

There was a clinical leadership presence in ED. Staff said it was easy to access and locate the consultant in charge of the shift. Each shift had a nurse in charge who was supernumerary and not rostered to deliver direct patient care. This meant they could provide leadership and support the staff on duty. The paediatric ED had its own nurse in charge.

During the inspection we found these nurses to be knowledgeable, approachable and enthusiastic about the team and the patients they cared for.

Leaders and senior leaders were passionate about the department and we saw although they had significant challenges at the time of the inspection, they acted to support the department and staff.

The ED was in a challenged position due to capacity and flow and senior leaders acted upon the daily challenges to address immediate patient safety concerns in an appropriate manner. We saw examples of senior leaders escalating patients who had been in the department for a long time and contacting other services where required to escalate the care requirements.

We found an improved culture since the last inspection in 2019. Staff spoke highly of the ED leadership team, consultants and senior nursing staff, saying they found them supportive, approachable and collaborative. During the inspection we observed many interactions between staff and leaders and it was evident there were close working relationships amongst staff of all disciplines.

Vision and Strategy

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

The trust's vision was "Working together to drive excellence in care for our patient and communities". This was supported by the trust's values and strategic themes.

The trust defined performance success in delivering the strategic aims, in-line with their four core Trust values of '*working together for patients, with compassion, as one team* and *always improving'.*

The service had developed its own vision and strategy, and these were aligned to the trust's ambitions. Staff across the emergency department knew about the service vison and strategy.

The service vision was described as:

Urgent and emergency services

Fulfil our role for the communities we serve.

Support safe, high quality patient focused care.

Take responsibility for the delivery of care now and in the future.

Invest in the capability of our people to deliver our vision.

Build the foundations on which our team can best deliver care.

Leaders in ED could describe their strategy for developing sustainable services. These were directly linked to the agreed new build of the ED. In the meantime, leaders had taken action to improve services and pathways for patients, for example by opening the emergency care centre and improving the streaming process for walk-in patients.

Culture

Staff generally felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted an open culture where patients and staff could raise concerns without fear.

The ED leadership team, together with the trust and staff, had worked hard to change and improve the culture of the department. During the inspection it became clear the emphasis was on making staff feel respected, valued and supported whilst delivering quality care to the patients. Most staff said they felt valued and supported by their immediate managers and spoke highly of their jobs. They said there was good teamwork and peer support.

A small number of staff however told us that at times they had not always felt respected, supported and valued by senior managers. They shared they had not always felt like there was an open culture where staff could raise concerns without fear. However, they acknowledged leaders were focused on improving and were working together to help facilitate changes.

The service had a positive culture, promoted staff and patient engagement and opportunities to improve services from feedback. Staff meetings often started with a patient story, developed from patient or relative's feedback. The patient story could be positive, to boost morale and highlight good practice. Alternatively, if the feedback reflected a less than positive outcome, the story was used as a learning opportunity.

The service had a freedom to speak up guardian and routine staff engagement to enable staff to share concerns or positive feedback. However, some staff said they were unsure who the guardian was or how to access them. Most staff said they would raise concerns directly with their line manager and, when they had done so, they had achieved a positive outcome.

Staff recognised the demands on the department and the increased patient numbers. Staff said the additional demand had impacted on staff welfare and expressed concerns they could not sustain the level of activity longer term. The trust and local leaders had implemented additional welfare and emotional support for the staff team in response to these concerns. Staff described how they could access additional support through the trust wide occupational therapy department.

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Staff reported teams worked effectively together, with staff across all areas respecting each other and working together to provide the best possible care and treatment to patients. We observed positive and caring interactions between staff and their patients and their relatives who used the service. Staff were patient focused and all staff we saw and spoke with wanted to provide the best care they could. We also noted the friendly and respectful interactions between ED staff of all grades and disciplines.

Despite the challenges, staff working across ED said there had been a change in culture since our last inspection in 2019. They told us the culture was now one of positivity with a real sense the department was moving forward together.

Staff described the good atmosphere in the team, even when staff were under pressure, and as a team, how they shared the stress. Staff said that during busy or challenging times relationships could sometimes become strained, but they appreciated pressures they were each working under and how that can affect behaviour.

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 service had established governance systems. ED governance meetings occurred monthly, with attendees from multidisciplinary staff across the service and reported to the divisional team.

There were clear lines of accountability from the department to the board, through the trust's governance structure. All levels of governance and management functioned effectively and interacted cohesively with each other. Staff at all levels could describe the governance structure and demonstrated how their role fitted within the structure.

Governance meeting minutes were comprehensive and covered a wide range of clinical and operational performance areas, for example risk management, mortality and morbidity, complaints, incidents and other key performance issues. Minutes reflected what we had been told by leaders and staff.

Management of the deteriorating patient and oversight of sepsis was a standing agenda item on department governance meetings. The trust had a medically led deteriorating patient group, information from this group both informed the trust board and support to the ED.

Senior ED staff said information from these meetings was disseminated down to staff in various ways. For example, at staff meetings, during handovers and safety huddles.

Information was escalated up to the trust board via the monthly divisional governance meeting. The ED team was represented by the governance lead and the ED leadership team at this meeting.

Trust and ED leaders had developed external relationships with system partners, for example local acute and mental health NHS trusts and also the local NHS ambulance trust. Leaders described how these relationships had strengthened governance arrangements and allowed for effective information sharing.

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.

Leaders and teams used systems to manage performance effectively. Leaders maintained an up to date risk register related to the department, this was reviewed monthly by the governance team and risk was escalated from ward to board dynamically as they emerged. ED risks included patient flow through the department, response to the COVID-19 pandemic, waiting times and ED capacity.

The service had developed effective systems and processes to capture real-time and longer-term data. Leaders and teams used the data to understand, manage and respond to pressure and demand within the ED. For example, waiting room capacity was monitored to understand timing and flow relating to self-presenting. Additionally, ambulance arrival and handover times were captured. Leaders used this data to support service planning, for example to determine when more staff are needed to cover busy periods.

Staff used feedback from governance meetings to improve the patient experience, increase staff knowledge and skills and improve the patient experience.

The hospital had a full capacity protocol when the number of patients occupying the department was beyond the capacity for which it was designed and resourced to manage. The service used the protocol alongside the escalation triggers when there was a surge in activity and when there was insufficient staffing to manage normal activity.

Leaders used established escalation processes to manage crowding and demand within the ED. Processes for managing ambulance handovers were embedded, and the service had surge plans to deal with times of increased demand.

The service had a systematic corporate programme of clinical and internal audit to monitor quality, and operational processes in the department. This helped leaders understand and analyse performance issues and put measures in place to address them.

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.

The service used information gathered through electronic recording and performance monitoring to determine specific audits and workstreams to make improvements in the department. The service told us about overarching quality improvements that were ongoing, for example, a nurse staffing review, a review of streaming in the department and the development of electronic assessments for specific patient conditions.

The department used various IT systems to collect, analyse and share information within the department and the wider trust. Trust data analysts collected, analysed and provided weekly data to the trust and the department. The data had been used to determine key areas of challenge, such as busy times of the day or week and numbers of patients using SDEC pathways.

Patients were tracked through their ED journey by an electronic computer system. The department could monitor its performance on a live basis through an electronic patient dashboard. For example, monitoring the patient waits in the department and the patient decision to admit status.

The dashboard was constantly monitored by dedicated staff in the department who could see the department's live activity and operational performance. The information was also shared at the trust's bed management meetings which occurred throughout the day to monitor and coordinate patient flow through the hospital. Additionally, members of the trust operational executive team had monitors in their offices displaying live trust information.

Engagement

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

Leaders actively promoted engagement with internal and external stakeholders. Staff meetings and safety huddles were an everyday occurrence. Leaders encouraged staff to share ideas for improvement.

Staff said they were encouraged to suggest ideas for improvement, and they would be actioned where practicable.

The service was engaging with local commissioning groups, the integrated care partnership and other local healthcare providers to specifically address local challenges. We saw and were told of various streams of work under development including redirecting patients to the correct services within the community. They had collaborated with external NHS providers to support safe care and improvements to the service and for patients. This included working with the local mental health NHS trust and the local ambulance NHS trust.

Leaders used IT based systems to hold meetings due to the impact of the COVID-19 pandemic, and these were now embedded practice to maintain communication, manage performance and governance oversight.

There was no forum currently the service used to formally engage with patients or equality groups.

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 hospital and the department actively encouraged staff to find ways to improve quality of care and outcomes for patients. We saw a number of initiatives aimed at improving performance and patient experience in the ED.

For example, ED was engaged in the national innovation 'NHS 111 First' and implemented direct bookable services to try and reduce the increased attendances to ED. The project group was supported by system partners from the local clinical commissioning group (CCG), NHS ambulance service and other community health care providers.

The trust and service had re-developed patient pathways and created new facilities to provide care for patients. The service had opened additional clinical areas based on pathways proposed and developed by trust staff. These included the nurse-led emergency care centre for ambulatory patients and the enhancement of the Same Day Emergency Care (SDEC) model. The SDEC included a separate ward area for older people to be cared for in a more appropriate setting.

The trust IT department had worked with ED staff and the local ambulance trust to develop an automated solution to transfer ambulance crew handover information directly into the trust electronic patient record. This had received a nomination for a national healthcare award.

The research team at the trust had dedicated research nurses and research work was being carried out in the ED. For example, research nurses told us they were involved in a research programme regarding the timing of prescribing antibiotics for patients suspected of having sepsis.

Clinicians in ED were working with the local ambulance trust on their project whereby ambulance crews could telephone ED clinicians prior to conveying a patient to the ED to determine if that was the most appropriate pathway. The project had recently started at the time of the inspection and outcomes had yet to be determined.

Medical care (including older people's care)

Good

Is the service safe?

Good

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

Mandatory Training

The service 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 trust had set a target of 85% of staff to have completed mandatory training. This had been achieved across all the wards.

The mandatory training was comprehensive and met the needs of patients and staff. The training was aligned to the skills for health core skills framework and included all key topics. Managers monitored staff attendance at mandatory training and alerted staff when they needed to update their training. Each area had an electronic system to monitor when staff training was due and notified staff to complete the training. Ward managers told us staff who had yet to complete training had a date to do so.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. The trust had set a target of 85% for staff attendance at safeguarding adults and children training. All departments in medicine had exceeded this target in all staff groups.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff gave us examples of identifying vulnerable adults and completing all the necessary steps according to internal policies and national guidance.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff could clearly describe what a safeguarding concern was and how to make a referral. Each area had visual prompts for the process and the safeguarding adult and children's policies were available for reference on the trust intranet. We reviewed two safeguarding referrals and found them to be completed correctly.

Cleanliness, infection control and hygiene

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

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

Medical care (including older people's care)

The service generally performed well for cleanliness. Cleaning records were up-to-date and showed all areas were cleaned regularly. All areas displayed the cleaning schedule, and these showed the cleaning had been completed. Cleaning staff were trained how to clean to minimise the spread of infection. Staff followed infection control principles including the use of personal protective equipment (PPE). All ward areas had dispensers of clean gloves and masks. Antibacterial hand gel dispensers were available, and posters prompted staff and visitors to clean their hands regularly.

Staff were all bare below the elbow and during the inspection all grades of staff cleaned their hands regularly. Each bay and side room on the wards had clinical handwashing sinks and a poster reminding staff of the five moments of hand hygiene. We reviewed hand hygiene audits from the previous 12 months and saw that compliance was above the trust target of 95%.

We observed staff cleaning equipment after patient contact. However, we did not see “I am clean” stickers being used consistently to label equipment to show when it was last cleaned. This meant that staff could not be aware of cleaning that had been completed. We raised it with ward managers who said these would be used consistently in the future.

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 followed national guidance. All areas we visited met the standard set out in Health Building Note 04 – In-patient care.

Staff carried out daily safety checks of specialist equipment. Safety checks were carried out on all specialist equipment including the resuscitation equipment and records of this were fully completed.

Electrical equipment in each area had been safety checked and maintained so was safe to use. Each piece of equipment had an asset number which allowed the trust to monitor when it was due for routine maintenance. Environmental audits from August 2021 to April 2022 showed compliance above the trust target of 95%.

The service had suitable facilities to meet the needs of patients’ families. There were water fountains and coffee machines. Visiting restrictions had been lifted, in line with current national guidance, with slots between 10am-2pm and 5pm-7pm. The visitors had to book in advance and complete a lateral flow device test for COVID-19 before attending. Waiting areas were visibly clean and tidy. Restrooms available to patient, visitors and staff members were all visibly clean.

The service had enough suitable equipment to help them to safely care for patients. Staff could access all the equipment they needed to provide care.

Staff disposed of clinical waste safely. Waste was separated and stored securely before being disposed of safely. However, we saw some sharps bins which were overfilled, and some without the temporary lid used correctly. We raised this with ward managers who told us they would remind staff at daily huddles about the importance of ensuring the sharps bins are used in line with national standards.

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. The National Early Warning Score (NEWS) was used in the service to identify patients at risk of deterioration. The form was within the patient pathway document. Scores were completed correctly. When a concerning score had been calculated the patient would be escalated for medical review.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff told us they would liaise with the mental health team to review patients who were at risk of suicide or self-harm. The team would review the patient within 24 hours and would formulate a plan going forward, which would take into account future care and how discharge would be managed.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. The patient pathway document included a range of risk assessments which included – falls, pressure areas, sepsis, nutrition and venous thromboembolism (VTE). Staff knew about and dealt with any specific risk issues.

However, staff were not completing the sepsis six pathway according to the deteriorating patient trust policy and national guidance. Further, the service completed a limited number of sepsis audits. We found two patient notes of the total we reviewed where sepsis had been documented, but the pathway had not been completed on the paper form. We raised this with the provider during and after our inspection. The service explained that they were in the process of updating the forms and the policy, and that this would be completed from May 2022.The service planned to record and monitor sepsis electronically from May onwards.

Staff shared key information to keep patients safe when handing over their care to others. Staff used a handover sheet to record key information when handing over care to other staff.

Shift changes and handovers included all necessary key information to keep patients safe. Each area had a safety huddle twice a day. All staff on duty attended the huddle and were updated on all key information.

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. 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 trust used the safer staffing model to adjust the planned staffing numbers according to patients' needs.

The ward manager adjusted staffing levels daily according to the needs of patients. The number of nurses and healthcare assistants matched the planned numbers. Records for the last month showed all areas had met or exceeded their planned staffing numbers. The service had low vacancy and sickness rates. However, staff we spoke with felt staff turnover was high in the department and trust wide information reflected a trend of increasing turnover since August 2021. The April 2022 trust wide turnover rate was 14%, up from 10.5% in August 2021.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service. During the inspection staff could describe how they orientated a temporary member of staff to ensure patients were kept safe.

Medical care (including older people's care)

The trust had some actions developed to reduce short-staffing risks, such as matrons reviewing staffing five days in advance to identify any hot spot areas, discussing staffing during daily huddles, and escalating any risks, matrons escalating any concerns regarding staffing at trust staff meetings. Further, the nurses in charge contacted staff contacted via WhatsApp group/telephone and offered overtime/excess hours/to swap shifts.

Staffing issues were discussed monthly at the trust board meeting and actions were agreed to make any necessary changes.

There were opportunities for further learning and development; staff told us there were opportunities for them to progress and to access additional courses.

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. Trainee doctors received support from a dedicated educational / clinical supervisor who was allocated before they arrived in the department. Supervision was discussed at induction and during their initial supervision meeting. They were informed of who to contact within and out of hours.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. There was consultant cover 12 hrs per day 7 days per week and on-call consultant support over phone 24 hrs a day 7 days per week. There was also a stroke consultant available 24 hrs a day, 7 days per week.

Records showed the medical staff on duty matched the planned number. The service had reducing vacancy rates for medical staff. There were reducing rates of bank and locum staff. Managers could access locums when they needed additional medical staff. They made sure locums had a full induction to the service before they started work.

Staffing issues were discussed monthly at the trust board meeting and actions were agreed to make any necessary changes.

Junior medical staff had access to support and teaching and felt positive about ongoing development opportunities.

Records

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

Patient notes were comprehensive, and all staff could access them easily. Most records were clear and up to date. However, of the 20 patient notes we reviewed, three had incomplete fluid charts. When patients transferred to a new team, there were no delays in staff accessing their records.

Records were not always stored securely. Notes trollies were unlocked and stored against the wall next to the nurse's station. Staff said this was for ease of access to notes. We raised this during our inspection and staff gave us assurance that this would be addressed urgently.

Medical care (including older people's care)

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, storage was not always temperature monitored.

Staff followed systems and processes to prescribe and administer medicines safely. All patient notes and prescription charts we reviewed were complete and in line with internal policies and national guidance and staff gave us examples of achieving this.

Medicine supply to wards was managed from the main dispensary supported by a robotic dispensing unit that managed both named patient and ward stocks. Ward based clinical pharmacy teams worked to ensure medicines were prescribed safely and in a timely fashion from admission to discharge, and that patients had the information they required relating to the medicines they took home. We saw that staff followed NICE (The National Institute for Health and Care Excellence) regarding medicines reconciliation. This meant that patients received their prescriptions within the correct timeframe and there was

Medicines advice and supply were available seven days a week. There was a dedicated medicines information telephone line between 9am and 5pm for staff and patients should they have any medicines queries. An out of hours service was available through the switchboard. Staff were well-informed of this and knew the routes to contact pharmacy at all times of the day.

On the wards, medicines were stored safely in dedicated secure storage areas with access restricted to authorised staff. Keys were kept in the possession of a dedicated member of staff. Medicine trolleys and patient's bedside lockers were also used.

We reviewed the trust wide medicines reconciliation policy for adults, which was included in the medicines management policy, and both were detailed and met national guidance. Medicines reconciliation is the process of identifying an accurate list of a person's current medicines and comparing it with the current list in use. We also saw that staff followed NICE (The National Institute for Health and Care Excellence) guidelines regarding medicines reconciliation. The hospital monitored and audited medicines reconciliation under pharmacy KPI-s (key performance indicators) and had set a target of 80% for medicines reconciliation within 24 hours of admission. At the time of our inspection the status was 78%, and there was an action plan to increase up to 80% and meet the goal.

Medicines refrigerators temperature records showed medicines were stored at the correct temperatures. There were weekly medicine audits where all medicines were checked, discarded if out of date and reordered. However, on some wards in the treatment room, where medicines were stored, temperature was not monitored or controlled. This meant that medicines stored outside the fridge could be kept at temperatures outside the specified range. We raised this with the service, who explained that this was due to recent building reshuffles. The provider gave assurance that they would address this urgently following our inspection. Monthly reported incidents including for medicines were discussed and shared at ward meetings.

Incidents

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

Medical care (including older people's care)

All staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy via an electronic reporting system. Staff said they were encouraged to report incidents and near misses.

Managers shared learning with their staff about never events that happened elsewhere in the hospital and trust. There were no never events on any medical wards. Each area had monthly meetings and learning from incidents was a standing agenda item. Learning from incidents had been shared at the previous three meetings.

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

Staff received feedback from investigations of incidents, both internal and external to the service. Staff told us they received feedback from their managers about the incidents they reported.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. The trust had adopted an incident review process called patient safety investigation report. Patient safety incident investigations were conducted to identify new opportunities for learning and improvement. Patient safety incident investigations focused on improving healthcare systems not individuals, they did not determine or apportion blame. We saw a completed investigation which focused on areas of good practice, care delivery problems, service delivery problems, root causes, concerns raised by family, immediate safety actions and a final risk rating. The findings had been shared with the staff and the family of the patient who had died.

We reviewed minutes of the patient safety meetings from the previous 12 months and found they included detailed information, learning and actions to improve and mitigate risks.

Managers debriefed and supported staff after any serious incident. It was evident the wellbeing of the staff involved in incidents was considered and they were supported throughout the investigation process.

Safety Information

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

The service continually monitored safety performance and data was displayed on wards for staff and patients to see. Every ward had a notice board with the safety data displayed. This data included number of falls and pressure ulcers.

Staff used the safety data to further improve services. At the time of our inspection, the service was implementing a project aimed at reducing the number of falls.

Is the service effective?

Good ➔➔

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

Medical care (including older people's care)

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff used a patient clinical pathway record to plan, give and evaluate care and treatment. The document referenced National Institute for Health and Care Excellence (NICE) guidance for each plan of care. NICE and trust guidelines were available on the trust intranet. Staff said guidance was easy to access, comprehensive and clear to follow. They showed us how they accessed the guidance.

We saw clinical practice reflected guidance and best practice. Key issues in patient care were handed over and acted upon. Senior clinical staff gave clear direction and support to junior staff and ensured patients received care and treatment based on national guidance.

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 saw patients regularly being offered hot drinks and snacks. Fresh water was freely available and kept topped up by staff. Patients were offered three hot meals a day and there were two planned rounds in addition offering snacks such as biscuits or cake. Patients were supported to eat and drink if needed. Patients were generally positive about the quality and quantity of the food provided. We also observed staff caring for two patients who needed special feeding and hydration techniques.

Staff generally completed patients' fluid and nutrition charts where needed. 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. Patient records in relation to nutrition were complete and up to date with dietitian reviews if needed. Nutrition and fluid care plans were generally followed with fluid balances totalled and acted upon appropriately. However, of the 20 patient notes we reviewed, three had incomplete fluid charts, where the output was not stated. This is a risk to providing safe care, and we raised the gaps with the ward manager on the day of our inspection.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff gave us examples of supporting patients with specific dietary requirements. We looked at the menus used, which were varied and included suitable alternatives for a range of religious or cultural needs.

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 pain relief according to individual needs.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients received pain relief soon after requesting it. Staff prescribed, administered and recorded pain relief accurately.

Medical care (including older people's care)

Patients told us any pain they experienced was well managed and staff responded promptly if they needed pain relief. Staff monitored pain level of patients and recorded the information. Pain scores were recorded in most patient notes. Staff used pictorial aids to assess the pain of patient who could not communicate verbally.

Patient outcomes

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

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers and staff used the results to improve patients' outcomes. Staff completed a variety of clinical and environmental audits to provide assurance about local practice in their areas.

The trust participated in relevant national clinical audits. Clinical audit was being undertaken and there was good participation in national and local audits. The trust performed in line with national clinical audits and had not been identified as an outlier in any of the national audits in the last year. National audits the trust took part in were: the lung cancer audit, national audit of diabetes inpatients, national audit of breast cancer in older patients, national prostate cancer audit, national hip fracture database, national audit of dementia, myocardial ischaemia national audit project, heart failure audit, chronic obstructive pulmonary disease audit.

In the last two years, the trust had appointed two new oncologists and bought a new CT scanner to improve care for lung cancer patients throughout their pathway. Following concerns about compliance with diabetes national audits, the diabetes team issued an action plan covering the themes from the national audit.

Competent staff

The service made sure staff were competent for their roles. However, managers did not always appraise staff's work performance 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. Staff told us the trust induction programme was detailed and comprehensive and provided all the information and support they needed to do their jobs.

Managers supported staff to develop through yearly, constructive appraisals of their work. The trust had set a target of 85% of staff to receive a yearly appraisal. The wards we visited had recorded appraisal completion rates ranging from 80% to 100%. All wards had an action plan to complete appraisals for staff within the next three months.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. Specialist teams provided regular targeted training to ward staff to maintain their specialist skills.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Team meetings minutes for the previous three months showed they were well attended by all grades of staff. Teams received electronic copies of the minutes.

Medical care (including older people's care)

Multidisciplinary working

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

Throughout the inspection we saw multidisciplinary team working in all areas. Clinical staff said nurses, doctors and allied health professionals worked well together within medicine and felt part of the team. These discussions were also evident in the patient notes we reviewed. All the notes we reviewed contained details of multidisciplinary working also involving the discharge and community teams. Further, staff gave us examples of good collaboration between medical wards, pharmacy and the discharge unit.

Staff held regular and effective multidisciplinary meetings to discuss patients' treatment and to ensure they are receiving the correct treatment and care. There were daily multidisciplinary board rounds where doctors, nurses and allied health professionals discussed patient care.

The mental health liaison team was available for advice and to support ward staff care for patients with mental health needs. Staff told us that they felt very well supported.

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

There were medical consultants working seven days a week. At weekends consultants were on site between 8am and 8pm. At other times, a consultant was available for advice or to attend the hospital in an emergency.

The trust provided diagnostic radiology such as scans or x-rays at the trust seven days a week.

Allied health professionals which included physiotherapists, occupational therapists and pharmacists were only available on weekdays.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards. We saw posters and information leaflets throughout the service for patients and relatives to promote a healthy lifestyle. For example, we saw a poster about living well with cancer.

Cancer patients were offered a recovery programme after treatment which included exercise, diet and access to a clinical psychologist. The aim was to support patients to return to a normal life after their treatment.

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, and generally recorded consent clearly in the notes. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Medical care (including older people's care)

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in most patients' records we reviewed. However, we found one situation where the patient's lack of capacity had not been countersigned by a consultant. This is not in line with national guidance. We raised this with staff on the day of our inspection, who acknowledged the lack of oversight.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. During the inspection staff could clearly describe the correct process for establishing the capacity of patients to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, considering the patients' wishes, culture and traditions. Records of patients who had been assessed as not having capacity and where staff made care decisions based on the best interests of the patient were completed correctly.

Records showed 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 the access policy and get accurate advice on Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff we spoke with could describe the policies and show us where to access them on the intranet. Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

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. Staff ensured curtains were pulled around the bed areas to provide privacy when needed. Staff of all grades spent time interacting with patients.

Patients said staff treated them well and with kindness. Patients thought the staff were kind and took time to understand and meet their needs. Staff told us about supporting a patient's partner and making arrangements so that they could be present when they passed away.

The Trust had recently introduced family liaison officers (FLO), to provide compassionate support and enable patients to communicate with their families, as well as ward companions, who were non-clinical staff and volunteers with additional training who cover various defined roles on wards, outside the roles they are contracted for. This was to support patients and staff.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Medical care (including older people's care)

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff caring for patients with complex needs who needed assistance with eating and personal care activities. We saw posters with the "ten absolutes of caring for people with dementia" on medical wards.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We saw a staff member helping a patient living with dementia who had become confused on the ward. The nurse walked with the patient to explain where they were and why they were in hospital and then helped the patient back to their bed, checking if anything else was needed.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. All staff we spoke with felt very proud for being able to dedicate time and give personalised care to patients.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. The trust provided a bereavement service for families who had a relative die when in the hospital. This service provided emotional and practical support for families who had been bereaved.

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. Patients told us staff had clearly explained their care and treatment and we saw clear communication between staff and patients. We also reviewed ten `positive event` sheets from medical wards, showing very positive feedback, such as "staff were welcoming and offered me a warm drink on my arrival", or "we would like to express our thanks and appreciation to all your teams for the excellent service they provide for people with palliative and end of life care needs".

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. There were many posters on all the wards we visited with options for giving feedback, either paper based or electronically. Patients gave positive feedback about the service. All areas invited patients to provide feedback using the national Friends and Family Test (FFT) system. All ward areas collecting FFT data had an average of 92.43 positive feedback response for April 2022.

Staff supported patients to make advanced decisions about their care. The trust had an end-of-life team who specialised in palliative and end-of-life care. This team supported both patients and staff to make advanced decisions about care.

Staff supported patients to make informed decisions about their care. All areas had leaflets explaining procedures and medical conditions which informed patients about their care. Staff had access to specialist teams who supported patients. For example, cancer, diabetes, stroke and mental health specialist teams visited the wards regularly.

Patients had access to support groups for various conditions. These met monthly and in person normally. During the pandemic the meetings went online to allow them to continue.

Is the service responsive?

Good 

Medical care (including older people's care)

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

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 to ensure they met the changing needs of the local population. Staff made sure patients living with mental health difficulties, learning disabilities and dementia, received the necessary care to meet all their needs. Staff were all aware of the dementia support team and their contact details and reported a good collaboration with them.

Patients could reach call bells and staff responded quickly when called. Patients who needed enhanced observation were allocated beds in bays next to the nurse's station.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. There were 21 reported breaches in the past 12 months. The trust had documented all the details for the breaches and reported no harm had occurred as a result. However, staff told us they did not always have time to report the breaches and that the numbers were higher in reality.

Facilities and premises were appropriate for the services being delivered. Waiting areas, clinical rooms and bays contained the required equipment according to internal policies and national regulations. The premises were mostly airy and welcoming. However, signage in the building and on the website did not reflect the reality on site and we met patients and carers who struggled to find the department they needed and asked for our help. We raised this with the provider, and they informed us that they were aware of this issue, and relied on volunteers to guide patients, carers and visitors. However, we did not see volunteers helping with directions when we visited the medical care areas.

Meeting people's individual needs

The service was generally inclusive and mostly 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 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 were aware of the mental health liaison team and knew how to contact them for support. Staff told us they had a good relationship with the mental health support team, who were very responsive, arriving within minutes of their calls.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff on medical care wards worked closely with the learning disabilities, mental health and dementia teams. Staff we spoke with all knew contact details for these teams and reported good working relationships with them. Staff were able to give us examples of supporting patients in need of additional support.

Staff gave us examples of supporting patients with protected characteristics. Protected characteristics according to the Equality Act 2010 are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. Staff also completed their mandatory training on equality, diversity and inclusion and showed a good understanding of the course. One example involved a patient from the LGBTQI+ community who received end of life care, where staff ensured that the patient felt understood and included. Further, we saw several posters welcoming people from the LGBTQI+ community on medical wards.

Medical care (including older people's care)

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Medical staff explored mental health with patients and sought to understand patients' individual needs outside of their immediate physical health condition.

Wards were designed to meet the needs of patients living with dementia. Staff on the wards told us about various materials and folders available to staff to use when communicating with patients with dementia. We also saw the materials, which were fit for purpose. Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff had access to "this is me"/ "about me" patient passports which provided information about patients living with dementia, who were not able to communicate their preferences verbally. Staff wrote some patient details on a whiteboard behind each patient's bed. This included the patient's preferred name and most of the time, staff used the preferred name.

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, translators or signers when needed. Staff knew how to book interpreters, translators and signers and were able to give examples of when they used interpreters to support patients and carers.

Staff were able to give examples of good collaborative practice, such as liaison with other hospitals when a patient was transferred which included timely transfer and updates to care plans. Staff also told us the procedure was successful and the patient's family were happy with the care they provided.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff had access to communication aides to help patients become partners in their care and treatment. Reception areas had hearing loops to communicate with patients and their carers or family. Staff had access to an equipment library to support patients with learning disabilities, and patients who communicated in ways other than speaking. Staff showed us the materials and explained how they used them. Staff gave other examples of supporting patients with communication difficulties.

Access and flow

People could generally access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Data from the Healthcare Quality Improvement Partnership (HQIP) National Benchmarking showed that the Trust had no negative outliers in the previous six months. The total number of medical outliers for the previous 12 months had reached 13,505.

Managers generally monitored patient moves between wards and ensured they were mostly kept to a minimum. We reviewed data from May 2021 to March 2022, indicating that there had been 1635 bed moves from midnight to 6 AM.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs.Staff reported a good collaboration with the integrated discharge team. Staff clearly understood the process for patients due to be discharged. We observed a medical team providing discharge instructions to a patient. These were clear and set realistic time scales for what time the patient could leave the hospital. However, staff we spoke with told us they felt under pressure in the discharge unit due to staffing levels.

Medical care (including older people's care)

Generally, managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. Staff had arrangements for patients in the discharge lounge to be collected within two hours if being collected by patient transport services. However, staff told us that the two-hour wait was being breached for some patients. We reviewed data from the previous 12 months and saw that there had been 15,093 delayed discharges.

Staff supported patients when they were referred or transferred between services. Staff supported patients with additional needs to be discharged to community inpatient hospitals, care homes or patients' own homes. The trust's integrated discharge team process, acute to community pathway and associated checklist were detailed and in line with national guidance.

Learning from complaints and concerns

It was generally 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. Staff understood the policy on complaints and knew how to handle them. Staff were able to explain the complaints process, and give examples of when a complaint was received, how it was handled and the outcome. The total number of complaints recorded in the past 12 months was 59, of which 35 had been closed. There was one potential case with the PHSO (the Parliamentary and Health Service Ombudsman) which the trust was still handling at the time of our inspection.

Wards and departments clearly displayed information about how to raise a concern in patient areas. We saw posters detailing the complaints process on four out of five wards. There were patient feedback leaflets on all the wards. Staff told us how the duty of candour was met, including recording of the process and the involvement of patients and families. However, the trust did not always respond to complaints within the timescales from their internal policies or national guidance. Of the 62 complaints we reviewed from the previous 12 months, 33 had exceeded the agreed deadline for completion, and 18 were still ongoing.

Staff understood the policy on complaints and knew how to handle them. Staff told us they would try to resolve complaints at the point of care, however if it could not be resolved they would give the patient and family their ward manager's details and PALS (patient access liaison service) information.

Managers investigated complaints and identified themes. Ward managers told us that they dealt with complaints or concerns and would speak with patients and their families directly. For formal complaints they investigated these and completed a report which was sent back to the patient relations team. Following this process and interactions with the patient and their families, lessons learnt would then be shared with staff.

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

Feedback from complaints was shared with staff in daily safety huddles, on ward rounds and in team meetings. Serious incidents which were at the origin of complaints were discussed with staff and escalated.

Is the service well-led?

Good 

Medical care (including older people's care)

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

Leadership

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

The medical core service was part of the medicine and urgent care division and was covered by a triumvirate which consisted of a group director, a group manager, and a senior lead nurse.

The triumvirate were supported by business partners for governance. The team held weekly senior operations meetings and attended weekly trust management meetings.

Wards were managed by ward managers who were supported by matrons. Staff commented that ward managers and matrons were visible and supportive.

On the wards we visited, ward managers had an open-door policy so that staff could speak to them and raise any concerns at any point. Ward managers were visible on the wards and supported staff when needed.

The division had identified gaps in medical staffing and were looking at ways to retain and increase staffing. The medicine care group had focused on international recruitment and was successful in supporting international recruits to practice in the UK.

Staff commented that they felt supported with opportunities for role development and career progression. Further, staff were encouraged to use the dedicated program allowing internal staff from black and minority ethnic backgrounds to progress and develop. We spoke to one member of staff who had recently progressed to a higher band through the dedicated program.

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.

Staff at all levels could describe the vision and strategy for their individual wards and the wider care group. We saw that the service had regular meetings with the finance and human resources departments to discuss best strategies to align with local needs. Each department was involved through a newly launched platform aimed at discussing and achieving possible cost savings with no impact on the quality of care.

Leaders told us that the care group management team would meet 1st June 2022 to finalise the vision and strategy; this will focus on the driver metrics of DEED (Delivering Excellence Every Day). Further, the newly formed senior management team for the care group were working towards setting new objectives and vision for the care group, taking into the new norm following the pandemic.

Culture

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

Medical care (including older people's care)

There was a culture of honesty, openness and transparency. Senior staff carried out the duty of candour responsibilities which detailed the involvement and support of patients or relatives in serious incident reports. Staff said there was an open and transparent culture where people were encouraged and felt comfortable to report incidents and where there was learning from mistakes.

However, most staff we spoke with did not know who the Freedom to Speak Up Guardians were, although they recognised the role and its importance This information was available on the intranet and through some posters on some of the medical wards.

Staff felt valued, supported and spoke highly of their jobs. Staff said there was good teamwork and peer support. Staff spoke enthusiastically about their jobs. Most staff felt they were able to progress and follow their clinical career path. Staff were passionate about getting the best results for the patients.

Staff were proud to work for the hospital; they were enthusiastic about the care and services they provided for patients. Some of the staff we spoke with had worked at the hospital for many years and described the hospital as a good place to work.

On the wards we saw multidisciplinary working which involved patients, relatives, and the clinical team working together to achieve good outcomes for patients.

Patients acknowledged a positive and caring ethos and were happy with their care.

Governance

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

There was a clear performance management reporting structure with monthly governance meetings looking at operational performance. This included a review of incidents reported, complaints, staffing, audit status, infection control, risks identified on the risk register and risk management, and education and training.

An extensive set of policies was readily available on the intranet and was supported by standard operating procedures and processes.

The care group triumvirate met on a weekly basis to review service-related issues and to agree any immediate actions to address quality and safety. Service line managers had daily huddles and monthly performance review with the care group triumvirate and presented at the care group quality assurance group.

Meetings were well attended by individuals with the appropriate level of seniority for decisions to be made. There was a standard agenda, which ensured discussion of clinical incidents and patient experience, as well as assurance reports from specialities within the care group.

We reviewed meeting minutes and saw there was enough level of detail to document the conversations that had taken place and the decisions made. Actions could be tracked, and minutes showed they had been completed.

Medical care (including older people's care)

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They generally identified and escalated relevant risks and issues and identified actions to reduce their impact.

Risks were recorded at ward division and trust level. The top three risks identified for medical care were delayed patient care due to lack of space to increase clinic capacity, delays to patient care due to inadequate diabetes specialist nursing staffing, and delayed patient care (outpatient access) due to inadequate endocrine nurse staffing levels.

Throughout the medical care departments, clinical and non-clinical managers worked well together to identify risks and make improvements. Matrons and ward managers had a good understanding of the issues within their clinical areas.

Leaders at all levels could generally describe the risks in their area of work and the mitigation in place to reduce the risks. The risk register was updated regularly, with risks added to the register relating to patient care, safety performance and current issues. Monitoring of risks and actions were allocated to named staff who recorded regular updates with the mitigations to reduce the risk.

However, the risk register did not include reference to the issues identified on inspection. There was no references or mitigation for monitoring, recoding and auditing sepsis. Further, the lack of temperature control in some clinical areas, particularly in medicines storage rooms, was not part of the risk register. We raised the lack of oversight relating to sepsis management with the provider.

Leaders told us that the sepsis and deteriorating patient policy would be updated soon after our inspection and that the sepsis pathway would then be used more consistently.

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.

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. There was an in-date information management policy which we reviewed and found to be detailed. Staff received training on information governance as part of their mandatory training, all staff on medical wards had completed the training. Staff could access policies, procedures and clinical guidelines through the trust intranet site.

Senior leaders told us about recent sustained efforts to cover complex mental health needs for patients, and how they had analysed data, and engaged with both clinical staff and finance departments to explore better ways of obtaining the required resources and ensure better care for patients with complex mental health needs.

Each area we visited had several computer terminals and computers on wheels to allow staff to access electronic patient records and test results. All staff had individual log on passwords and all terminals were locked when not in use.

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.

The trust involved patients and the public in developing services by involving them in the planning, designing, delivering and improvement of services. The various means of engagement included a range of patient participation groups such as the patient experience groups, the patient safety and experience meetings and feedback from the friends and family test and inpatient surveys. We reviewed minutes of the patient experience group meetings from the previous 12 months and saw that they were detailed and showed evidence of engagement with the public.

There were effective systems to engage with staff. Most staff told us they felt engaged, informed and up to date with what was happening within the wider trust. Information was shared through different forums. These included the staff survey, regular team meetings and verbally.

The trust took part in the 2021 NHS staff survey. The average score was 6 out of 10, with topics such as “we are compassionate and inclusive”, “we each have a voice that counts” and “staff engagement” obtaining the best scores.

The management team said any good ideas put forward by staff were discussed at weekly ward and monthly team meetings. Useful suggestions and good ideas were passed on to the clinical and quality boards. Staff felt informed and involved with the day-to-day running of the service and its strategic direction.

Staff advised us there were regular staff meetings and that managers arranged these for different times and days to ensure all staff were able to attend regularly.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation.

Senior leaders spoke about how the service had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements.

A ward had been awarded funding to improve care of dementia patients on the ward. Multidisciplinary education was planned, as the Practice Educator for Medicine and nominated junior doctors would be working closely to deliver education to nursing and medical staff.

We reviewed minutes of medicine governance meetings from the previous six months and saw that improvement actions had been identified and implemented.

Leaders told us about a new clinical cancer strategy developed following engagement with members of the public to improve the quality of the service. Further, a new chemotherapy service had opened in one of the community hospitals to ensure continuity of care and improved support for cancer patients.