

Sheffield Teaching Hospitals NHS Foundation Trust

Quality Report

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

Ratings

Overall rating for this trust

Good 

Are services at this trust safe?

Good 

Are services at this trust effective?

Good 

Are services at this trust caring?

Good 

Are services at this trust responsive?

Good 

Are services at this trust well-led?

Good 

Summary of findings

Letter from the Chief Inspector of Hospitals

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

We included the following locations as part of the inspection:

- Northern General Hospital
- Royal Hallamshire Hospital, including Jessop Wing
- Weston Park Hospital
- Charles Clifford Dental Hospital
- Community services including adult community services, community inpatients, community dentists, renal dialysis unit and end of life care.

We did not inspect the GP out of hours service based at the Northern General Hospital site.

We rated the trust as good. Royal Hallamshire Hospital, Northern General Hospital, Charles Clifford Dental Hospital and the community services were rated as good. Weston Park Hospital was rated as requires improvement.

Our key findings were as follows:

- The trust was led by a stable and respected board.
- We found the hospital was clean and staff adhered to infection control principles. The trust scored 99% for cleanliness in the patient-led assessments of care environments (PLACE) report for 2015.
- There was a trust infection control accreditation programme in place. This programme set standards for infection prevention and control practice. Most clinical areas had achieved accreditation; plans were in place where this was not the case.
- There had been four cases of MRSA reported by the trust between June 2014 and June 2015.
- There had been 88 cases of C.difficile between June 2014 and June 2015. This was a rate in line with the England average per 10,000 bed days. The trust's rate of C.difficile was below the trajectory target with 42 cases against a stretch target of 52 cases at the end of November 2015.

- The trust had a well-established governance framework in place and incidents were reported and actions taken in response.
- The trust used the safer nursing care tool, professional judgement and nursing hours per patient day to determine appropriate levels of staffing. There were some areas where staffing fell below planned levels on a regular basis, particularly in the Emergency Department and Weston Park Hospital wards, although the trust was mitigating risks as far as possible. Recruitment to vacancies was in progress. Staff were able to use bank or agency staff, where available, to fill staffing shortfalls.
- The trust was committed to the development of advanced nurse practitioners to ensure patient care was maintained and the potential recruitment difficulties to junior doctor posts mitigated. This also allowed good advancement opportunities for nurses.
- Mortality indicators showed no evidence of risk.
- Patients were assessed for their nutritional needs. The trust had introduced HANAT (hydration and nutrition assurance toolkit) to encourage good nutrition and hydration best practice in the hospital environment.
- We saw patients being cared for with kindness, dignity and respect and many services across acute and community patients told us they were very happy with their care.
- We saw examples of effective multi-disciplinary working across both acute and community services
- There was a well-established culture of continuous quality improvement. This was supported and assured by robust governance, risk management and quality monitoring. The trust used a Microsystems Coaching Academy which worked well to support small scale service improvements.
- The trust's vision and values were embedded in practice. These informed performance reviews and staff felt they were meaningful.
- Clinical directorates had individual five year strategies that were linked to trust's strategy, aims and objectives. The directorate strategies had consideration of the other clinical departments they worked with to deliver high quality care and the assistance required from corporate directorates and

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other partners. There was, however, no local end of life care strategy that provided an integrated acute and community vision of care for patients who were at the end of life.

- The trust did not record the preferred place of death for those patients coming to the end of life and there were occasions when patients had to wait for up to two weeks to access a bed on the palliative care unit.
- A culture of innovation and improvement was evident throughout all levels of the organisation.
- There were concerns regarding the emergency department at the Northern General Hospital this included the clinical decision unit. Specifically we had concerns regarding the quality of care of patients during times when the department was busy.
- There were concerns regarding the clinical decision unit specifically regarding the monitoring and escalation of deterioration patients in the seated area of this unit. We raised this with the trust at the time of inspection and a protocol was put in place.
- The introduction of a new IT system had resulted in the trust not being able to record performance targets in the emergency department.
- There were variable levels of compliance across both community and acute services for mandatory training levels. In the dental hospital staff had not received any training in Mental Capacity Act or Deprivation of Liberty standards.
- We were concerned about the use of the teenage and young adult unit for patients who required an acute bed.
- There was variation in the quality and completeness of Do Not Attempt Resuscitation (DNACPR) forms across all of the acute hospital sites.
- In medicine there were concerns regarding the access to nursing guidelines that were held electronically and could not always be accessed by agency nurses. Care was conveyed between nurses using the handover sheets rather than referring to the nursing care plan.

We saw several areas of outstanding practice including:

Community dental service

- A collaboration between the Sheffield Community Dental Services, NHS commissioners, Dental Public Health consultants and local general dental practitioners led to the development of the Residential Oral Care Sheffield service for residents living in care

homes. This collaboration was cited as good practice by the British Society for Disability and Oral Health. This service now covers 80 out of the 88 residential care homes who participate in the scheme in the city of Sheffield.

- The clinical lead was instrumental in developing a national benchmarking tool used by other community dental services and NHS dental commissioners for describing the complexity of patients treated by community dental services. An evaluation of the outcomes of the pilot project was delivered at the National Association for Dentistry in Health Authorities and Trusts in 2014.
- Collaboration between the Clinical Lead of Sheffield Community Dental Services and the Head of Psychotherapy Services within Sheffield NHS Foundation Trust developed a dental nurse led Pain and Anxiety Service. This led to a reduction in the numbers of patients needing intra-venous sedation for dental treatment and the overall waiting times for intra-venous sedation.
- Sheffield Community Dental Service provided a service for the Sheffield homeless under the auspices of the 'Archer Project at the Cathedral'.
- Sheffield Community Dental Service had developed a communication tool known locally as 'the widget sheets' enabling children with autistic spectrum disorders and other communication difficulties to accept dental treatment. An evaluation of this audit tool was published in the peer reviewed international scientific publication 'Journal for Disability and Oral Health' in 2014.
- The development of a number of nationally recognised clinical benchmarking tools by Sheffield Community Dental Service was a result of exceptional leadership provided by the current Clinical Lead of the Service.

Community Adults

- The active recovery service was a responsive service, which aimed to reduce un-necessary hospital admissions and facilitate the timely discharge of more complex patients from hospital. The team was multidisciplinary and multiagency with health and social care working closely together. The service had redesigned the traditional model of assessing to

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discharge to the more patient centred approach of discharge to assess resulting in reduced length of stay for patients and improved patient flow within the hospital.

- The Single Point of Access (SPA) service managed referrals from patients and health professionals into all community health services. The service used a call routing system to direct patients to the right professional from the start. The team had extensive local knowledge and specialist expertise and were able to access to up to date information on service capacity. This meant that they could ensure patients were seen by the right professional at the right time at a venue of their choice.
- We thought the person centred care planning was outstanding. The aim of this was to provide support for patients considered to be at high risk of hospital admission at an early stage. Community nurses and GPs worked together to develop patient and carers confidence in managing their own health. The community matron supported this. There were locality champions for person centred care planning in each of the four localities.

Northern General Hospital

- The patient care and experience delivered by staff in the Bev Stokes Day Surgery Unit was outstanding, particularly in relation to patients living with learning disabilities and dementia.
- The duty floor anaesthetist role in theatre developed in Sheffield was going to be used by the Royal College of Anaesthetists as a beacon of good practice.
- The development of a relative's room in the theatre complex.
- On general intensive care unit /general high dependency unit there was the use of an electronic patient information system to ensure timely and accurate records, access to trust and local policies, procedures and guidelines The system ensured effective care was delivered and it was fully integrated and provided real-time information across teams and services.
- An advanced clinical pharmacy service which included a consultant pharmacist and pharmacy prescribers had been developed to improve the safety and efficacy of medicines used in critical care.

- The use of the Enhanced Recovery After Thoracic Surgery (ERAS) programme had resulted in marked improvements in the quality of care for patients on cardiac intensive care unit (CICU).
- The laboratory team had introduced a 'Patient Safety Zone' project into the inpatient wards and in the community. The aim was to reduce labelling errors. Disturbance or distraction while taking blood samples has been identified as a major risk factor for errors. This initiative had been introduced to improve patient safety. Pathology staff showed us lots of publicity material, including branded biro pens.
- In laboratory medicine, we observed large screens above the bench dealing with urgent samples. It contained a full list of patients waiting for results in the accident and emergency (A&E) department. The same screens were on display in A&E. This meant laboratory staff could see exactly who was waiting in A&E and gave context and 'humanity' to the samples they were analysing. Urgent results for A&E samples were available in one hour because of the use of this management tool.
- Radiology provided an excellent service of 'hot reporting' for reporting x-rays for A&E patients; results were ready within 20 minutes.
- Geriatric medicine had historically been part of acute medicine but was now combined with community services to provide an integrated service.

Royal Hallamshire Hospital

- Staff in theatre had introduced a learning disability pathway. An operating list was dedicated to patients with a learning disability, if the patient needed more than one procedure this was carried out on the same operating list under the same general anaesthetic.
- The use of duty floor anaesthetist role in theatre, developed in Sheffield, was going to be used by the Royal College of Anaesthetists as a beacon of good practice.
- Radiology provided an excellent service of 'hot reporting' for reporting x-rays for minor injury patients; results were ready within 20 minutes
- Histopathology was using cross-site digital pathology to speed up processing time for frozen sections.
- On GICU and NICU there was the use of an electronic patient information system to ensure timely and accurate records, access to trust and local policies,

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procedures and guidelines The system ensured effective care was delivered and it was fully integrated and provided real-time information across teams and services

- An advanced clinical pharmacy service which included a consultant pharmacist and pharmacy prescribers had been developed to improve the safety and efficacy of medicines used in Critical care.
- The one to one team and specialist midwife clinics gave greater assurance that high risk women continued to have a choice on the care they received in pregnancy.
- The rapid access clinic reduced readmissions of babies with feeding problems.
- The GRIP project responsible for getting research into practice improved services for maternity and gynaecology.
- The termination of pregnancy service gave women continuity of care in an appropriate caring environment. The seven day service gave women choice and improved accessibility.
- The use of the Enhanced Recovery programme in both maternity and gynaecology improved the service for women.

Weston Park Hospital

- Specialised cancer services provided a patient-centred holistic approach to patient care where the whole multidisciplinary team worked together to ensure the patient's experience of the service was the best that it could be.
- The teenage cancer unit had a number of innovations which had been paid for out of charitable funds. These included a 'couples retreat' for end of life patients and their partners. They could spend time away from home and explore issues about coming to the end of life.

Community end of life care

- The intensive home nursing service provides support for patients and their families in the last days and hours of life. Relatives consistently praised the service and the staff who provided it.

Community inpatients

- Feedback we received from patients was consistently positive about the way nursing and therapy staff treated them. Patients told us that staff go the extra mile. Staff and patients confirmed that the unit had a flexible approach to care.
- Patients were supported emotionally. Activities such as singing, arts and crafts were arranged to prevent social isolation and boredom.

Charles Clifford Dental Hospital

- An holistic approach to individual patient's requirements was modelled within CCDH, and anxious patients had the option of utilising cognitive behavioural therapy (CBT), acupuncture, hypnosis, inhalation, or intravenous or oral sedation to assist with their dental treatments.
- Staff were sensitive to the needs of vulnerable patients, making reasonable adjustments to ensure that effective two-way communication was achievable to allow patients to be fully empowered to make decisions about their treatment options.
- The service worked with a local dental unit to provide an out of hours (17:00 – 20:00) oral surgery Consultant led clinic for patients who were unable to be released from work within core hours, enabling them to attend one evening each week.

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

Importantly, the trust must:

- The trust must ensure patients do not wait longer than the recommended standard for assessment and treatment in the emergency department.
- The trust must ensure that on initial assessment in the "pit stop area" in the emergency department patient's vital signs are taken and recorded consistently.
- The trust must monitor performance information to ensure 95% of patients are admitted, transferred or discharged within four hours of arrival in the emergency department.
- The trust must ensure the safe storage of intravenous fluids.
- The trust must ensure doctors follow policy and best practice guidance in relation to the prescription of oxygen therapy.
- The trust must ensure that guidance is followed in the documentation of foetal heart rate monitoring.

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- The trust must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty at Weston Park Hospital.
- The trust must ensure the divisional risk registers reflect issues in the emergency department demonstrate evidence of actions and reviews.
- The trust must ensure there is a clear strategy for the end of life care which is implemented and monitored.
- The trust must ensure that staff implement individualised, evidence based care for patients at the end of life.
- The trust must ensure that DNACPR records are fully completed.
- The trust must ensure that staff complete mandatory training in accordance with the trust policy

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Sheffield Teaching Hospitals NHS Foundation Trust

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

- Northern General Hospital
- Royal Hallamshire Hospital
- Jessop Wing Maternity Unit
- Weston Park Hospital
- Charles Clifford Dental Hospital

The trust also provides community services for the population of Sheffield.

The trust has 1,840 beds

- 1678 general and acute beds
- 97 maternity
- 77 critical care

The trust employs 15,976 staff

- 1,747 medical
- 4,466 nursing
- 9,763 other

The trust financial position:

- Revenue: £993,418,000
- Full costs: £985,027,000
- Surplus: £8,391,000

We carried out the inspection as part of the Care Quality Commission comprehensive inspection programme.

Our inspection team

Our inspection team was led by:

Chair: Professor Stephen Powis, Medical Director

Head of Hospital Inspections: Amanda Stanford, Head of Inspection

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

How we carried out this inspection

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

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

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

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

- Critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatients and diagnostics

We also inspected the Charles Clifford Dental Hospital.

The community health services were also inspected for the following core services:

- Community adult services
- Community end of life
- Community inpatient services
- Dental Services

Before the announced inspection, we reviewed a range of information that we held and asked other

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organisations to share what they knew about the hospitals. These included the clinical commissioning group (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), royal colleges and the local Healthwatch.

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

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

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

What people who use the trust's services say

From July 2014 to November 2015, the trust performed the same or better than the England average for the percentage of inpatients who recommended the trust in the Friends and Family Test.

Both the national maternity survey for 2015, which looked at the experiences of people receiving maternity services, and the national inpatient survey from 2014, showed the results for Sheffield Teaching Hospitals NHS Foundation Trust was about the same as other trusts.

Facts and data about this trust

Sheffield Teaching Hospitals NHS Foundation Trust is an integrated provider of health care with a two main acute hospitals Royal Hallamshire Hospital and Northern General Hospital, maternity services are provided at Jessop Wing and cancer services at Weston Park Hospital. The trust has a dental hospital, Charles Clifford Hospital. The trust operates their community services across Sheffield.

The trust activity for period September 2014 – August 2015:

- Inpatient admissions: 47,398
- Outpatients: 928,702


- A&E attendances: 137,416 (including 19,090 Minor Injuries attendances)

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

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

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Our judgements about each of our five key questions

	Rating
<p>Are services at this trust safe?</p> <p>We rated safe as good because:</p> <ul style="list-style-type: none">• The trust had appropriate systems and procedures in place to keep patients safe, including safeguarding and infection control.• In the patient led assessment of the care environment (PLACE) (2015) the trust scored 99% for cleanliness which was above the England average of 98%.• There was an established incident reporting system and policy in place which staff understood. We saw that lessons were learnt and actions taken.• There were appropriate staffing levels in most areas across the trust, staffing was reviewed using an acuity and dependency tool and professional judgement. There was ongoing recruitment and the trust had recruited 130 registered nurses, there were 150 vacancies remaining at the time of inspection.• There were process in place for identifying patients whose condition was deteriorating and staff were aware of the escalation procedures to follow. <p>However, we also found:</p> <ul style="list-style-type: none">• Staffing in the Emergency department at the Northern General Hospital was a concern with staffing levels falling below established levels on 49 shifts out of 63 shifts reviewed. The department had staff vacancies. There was a process in place to redeploy staff from other areas and to request agency staff.• There were concerns regarding the assessment and monitoring of patient risk particularly in the Emergency Department at the Northern General Hospital. We raised concerns regarding the clinical decision unit and the identification of the deteriorating patient in this area. This was addressed by the trust in response to our concerns.• On the neonatal unit, nurse staffing was not at current recommended staffing levels. Staffing levels at Weston Park Hospital were below the expected levels.• Concerns about the safe and secure storage of intravenous (IV) fluids in some clinical areas, medicines reconciliation and prescribing of oxygen.• There were concerns regarding access to nursing care guidelines in medicine as these were held electronically and could not always be accessed by agency or bank nurses.	<p>Good </p>

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Duty of Candour

- The trust was aware of its obligations in relation to the Duty of Candour requirements. The legal Duty of Candour requires the trust to disclose openly events that have led to moderate, major or catastrophic harm to a patient.
- The trust's incident management policy included guidance on implementation of the Duty of Candour and was available to staff.
- The trust's electronic incident reporting system had been adapted to prompt consideration of the Duty of Candour.
- Three levels of training had been implemented across the organisation on Duty of Candour. A leaflet introducing Duty of Candour was sent to all staff in early 2015 as part of the level 1 education.
- We found that staff were aware of the duty of candour requirements and could explain the principles of being open and transparent with patients, families and carers.
- During the inspection we reviewed six root cause analyses from serious incidents and saw that Duty of Candour had been applied.

Safeguarding

- The trust had appropriate safeguarding policies and procedures in place for both adult and children.
- The policies and procedures were supported by staff training. We found 86% of staff had received level 1 children's safeguarding training, 65% had received level 2 and 58% had received level 3 training against a trust target of 90%. A total of 85% of staff had received level 1 safeguarding vulnerable adults training and 75% level 2. Safeguarding leads were aware of the areas that had low compliance with training, such as the emergency department, and gave examples of action to improve compliance.
- The trust had a safeguarding committee which reported to the healthcare governance committee, a sub-committee of the board.
- The executive lead for safeguarding both adults and children was the Chief Nurse. The Deputy Chief Nurse had operational responsibility for safeguarding.
- There was a lead nurse for children and young people, lead nurse for safeguarding adults, named midwife and named doctor. In addition, each care group had a safeguarding lead who attended the safeguarding committee.
- A specialist team of ten whole time equivalent midwives worked to deliver a 24-hour service providing care and support

Summary of findings

for women with more complex social needs. The team performed daily maternity ward rounds and discussed new cases, ensuring all women within their caseload had a named midwife from the vulnerability team.

- Midwives were identified by a recent CQC review for looked after children, as high referrers for the Family Common Assessment Framework (FCAF) and to the local Multi Agency Support Teams (MAST) to elicit early support.
- The recent Care Quality Commission review of health services in safeguarding and looked after children services in Sheffield, noted “excellent examples of strong paediatric liaison”, and good liaison with children and young people mental health service (CAMHS) within the emergency department. However, they noted a city-wide reliance on telephone calls for referral concerns rather than written follow up information.
- The trust had a strong focus on safeguarding, for example in the emergency department a ‘Pathway for Vulnerable Young People’ had been developed in partnership with an external stakeholder. This had been highly commended at the National Children and Young People Awards.
- The trust had implemented an action plan in place in response to the Savile Inquiry.

Incidents

- The trust is part of the ‘Sign up to Safety campaign.’
- The trust reported 15,342 incidents reported in the period August 2014 to July 2015, of these 98% were of no or low harm. There were 29 serious incidents of which four were categorised as never events. Two of the never events occurred in 2014 and were surgical incidents at the Northern General Hospital and two occurred in outpatients at Weston Park during April 2015.
- The incident reporting rate is 7.2 per 100 admissions compared to the England average of 8.4.
- There was a weekly serious incident review group that was attended by the Chief Nurse and Medical Director.
- The trust has an incident management policy that set out the processes and lines of accountability for reporting incidents.
- Across the acute and community services, we saw established good practice of reporting incidents through an electronic reporting system. Staff were able to explain how they would report and escalate incidents.
- The 2015 National NHS Staff Survey found the percentage of staff who reported witnessing potentially harmful errors, near misses or incidents was in line with the national average. In the same survey, errors, near misses or incidents witnessed in the last month was 89%, which was also in line with the national

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average. Fairness and effectiveness of procedures for reporting errors, near misses and incidents was similar to the national average; however staff confidence and security in reporting unsafe clinical practice was worse than the national average.

- Grade three and four pressure ulcers were not always reported as serious untoward incidents; this was in accordance with new guidance and in agreement with the trust's commissioners. However, we saw evidence that root cause analyses were still undertaken within the trust.
- Human factors training was offered to staff.

Staffing

- Recruitment to registered nurse posts was challenging. Data from June 2015 showed there were 250.9 wte vacancies of nursing and midwifery staff at band 7 and below. This equated to 6.3% vacancies for this staff group across the trust. At the time of inspection the trust had improved staffing and recently recruited 130 nurses; there were 150wte registered nurse vacancies. This figure included staff that had been appointed but not yet started at the trust.
- There was an active recruitment process including bespoke recruitment for specific areas for example theatres and international recruitment was being pursued. Areas of concern regarding staffing included emergency care and care of older people which was reflective of the national staffing shortages.
- The average staff turnover rate was 7%. Staff turnover in the dental hospital was higher at 30% however this was a training hospital and turnover was attributable to trainees moving following completion of training
- At the time of inspection, the average staff sickness rate was reported as 4.4% against a trust target of 4%.
- Nursing bank and agency usage was low with 2% usage in March 2015.
- The trust utilised the Safer Nursing Care Tool, an acuity and dependency tool endorsed by NICE as part of its approach to review staffing levels. At the time of inspection the safer nursing care tool was being piloted in emergency department. The trust was joint authors of the Safer Care Nursing Tool. There was a formal staffing review every six months.
- New roles including enhanced training of non-registered nurses were being progressed within the organisation. The trust had approximately 600 advanced nursing roles to address service needs.
- A 'careers elevator' had been developed to allow staff to develop from apprentice through to registered posts.

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- Staffing in maternity was monitored using the midwife to birth ratio. The midwife to birth ratio was 1:28 which was in line with the Royal College of Obstetricians and Gynaecologists (RCOG) guidance.
- On the neonatal unit, nurse staffing was not at current recommended staffing levels. The staffing establishment for the ward was based on 2010 recommendations due to funding. The unit had a full establishment of nursing staff at the time of inspection. We found that staffing levels were consistently at 85% of the current national recommendations.
- In Emergency department at the Northern General Hospital there were concerns regarding current staffing levels; the department had 15 whole time equivalent (WTE) vacancies. We reviewed staffing rotas which showed that of the 63 shifts reviewed 49 shifts had staffing levels that were below established staffing levels. The trust had a process to redeploy staff from other areas and request agency staff; however from records we reviewed we were unable to see whether this policy was used at these times.
- The department had developed advance nurse practitioners to address gaps in medical staffing.
- We had concerns regarding the staffing in the resuscitation area of the Emergency department, particularly during times when major trauma cases were admitted. During the inspection we saw that during an admission of a major trauma case this resulted in one nurse looking after four patients in the resuscitation room. This had been highlighted by senior nursing staff as a key area for improvement.
- The senior management and executive teams were aware of the staffing issues in the Emergency department and had recently undertaken a safer staffing review which we were told had identified the need for approximately 42 WTE additional nursing posts. However, with the emergency department pathways changing this had been re-reviewed and 19 WTE had been agreed.
- In critical care, the Intensive Care Society and British Association of Critical Care Nurses (BACCN) standards were used for assessing patient acuity and staffing requirements. We found staffing levels were in line with national guidance and staffing shortfalls were met by using in-house bank staff and agency staff. However it was noted that there was not always a supernumerary clinical co-ordinator at the general intensive care unit at the Northern General Hospital.
- There was an established escalation process to identify and address short notice staff shortages. This involved moving staff

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to work in other areas. However, staff were unhappy that they were moved to cover other wards across hospital sites regularly and at short notice. Staff recognised the need to keep patients safe; however it was clear this had an impact on staff morale.

- Team leaders within the integrated community nursing teams reviewed the caseloads daily and allocated patients to nurses. Nurses visited on average 12 to 14 patients a day however this could vary dependant on the individual needs of the patients. A safe caseload tool had been developed and was being rolled out across community nursing to establish and record the dependency of patients.
- The trust had implemented a transfer register for nursing staff who wished to transfer to gain experience elsewhere in the trust. There were rotational programmes in place for example in elderly care and community services. These schemes we were told had helped with staff retention.
- The trust has the same proportion of consultant staff (39%) compared to the England average (38%) but has more registrars (48%) compared to the England average (38%) and the same proportion of junior doctors (16%) compared to England average (15%)
- Physician's assistants had been recruited to support the reduction in medical training posts.
- Staff told us of concerns regarding medical cover at Weston Park Hospital overnight, however we discussed this with the medical director and were assured that the trust had undertaken a risk assessment of this. A registrar was on site until 9pm and there were standard operating procedures to follow during the out of hour's period when there was no medical cover in the building. During this period, cover was provided by the hospital at night team based in the Royal Hallamshire Hospital.

Medicines

- The trust's medicines management policies were regularly reviewed. These were accessible via the hospital intranet to all staff.
- A self-medication policy was also in place. We saw seven patients who were self-medicating, but no documentation or formal assessment of their capability had been completed in line with the policy. Therefore we could not be sure patients were supported to take their own medicines safely, including the arrangements for risk assessment and care planning. We also found four examples of inhalers on bedside tables which were not stored securely.

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- Pharmacy staff checked (reconciled) patients' medicines on admission to wards. The ward-based clinical pharmacy service was available at Northern General Hospital and Royal Hallamshire Hospital between the hours of 9am to 5pm on Monday to Friday. A basic dispensary service operated at the weekends. A trust snapshot audit conducted in September 2015 showed 55% of patients' medicines were reconciled within 24 hours of admission by the pharmacy team. This figure had worsened since the last audit carried out in May 2015 which showed that 62% had been completed within 24 hours. National guidance [Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes, NICE 2015] sets a standard of 95% completed within 24 hours. Medicines reconciliation was on the medicines management risk register and there had recently been an increase in pharmacy staffing on the Acute Medical Unit (AMU) in an attempt to improve the service.
- Some aspects of medicines management were regularly audited across the trust including medicines reconciliation, medicines storage, medication errors and clinical pharmacist activity. However, some audits were lacking in scope and detail and action plans were not always put in place based on the results, for example with controlled drugs incidents. No audits of delayed or missed doses had been carried out in the last 12 months; a baseline audit was underway at the time of the visit prior to the introduction of electronic prescribing which would enable ongoing reporting of missed doses.
- Pharmacy audits on medicines storage and security in August 2015 had identified concerns about the safe and secure storage of intravenous (IV) fluids. They had a work plan in progress, however this remained a concern during our inspection and we found doors to medicines storage rooms were unlocked or wedged open on ten of the wards we visited. Some wards did not have locks fitted to medicine room doors at all. This meant that access to drugs and IV fluids was not restricted to authorised staff.
- We saw four patients receiving oxygen when it had not been prescribed despite there being a dedicated prescription included on drug charts. In one case the prescription details were incomplete. This was a failure to follow national guidance and meant that there was a risk of inappropriate administration and a lack of monitoring which could put patients at risk.
- Arrangements were in place to ensure that medicines incidents were reported, recorded and investigated through the trust

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governance arrangements. We saw examples of learning from errors being shared at ward and department level. Trends and patterns across the trust were identified and discussed at monthly safety and risk management board meetings.

- Patient Group Directions (PGDs) were in use in some clinical areas in the trust and these were prepared and used in a safe way. PGDs are written instructions which allow specified healthcare professionals to supply or administer a particular medicine in the absence of a written prescription. We checked PGDs used in the accident and emergency department at Northern General and saw they were being used effectively to support patient access to medicines in a timely way.
- Community services had a Head of medicines management. Pharmacists worked with community teams and had written and reviewed standard operating procedures to improve safety around medicines. We saw some examples of good practice in the community services. For example, the community pharmacy team had introduced the use of 'tiny tags' which tracked the medicines fridge temperature. Tiny tags were also used to check that cool packs were kept at the correct temperature when staff were transporting vaccines.

Infection Prevention and Control

- The trust had infection prevention and control policies in place, which were accessible, understood and used by staff.
- The trust had developed an internal infection control accreditation programme. This programme set standards for infection prevention and control practice with the aim to optimise and assess infection prevention and control practices in clinical teams throughout the hospital to reduce infection rates. The programme was in place across the acute and community services.
- Across both acute and community services patients received care in a clean and hygienic environments.
- Implementation of an annual rolling deep clean programme had resulted in a reduction in the cases of C.difficile.
- There were four cases of Methicillin Resistant Staphylococcus Aureas (MRSA) between June 2014 and June 2015, since then the trust has had no further incidents.
- In the patient led assessment of the care environment (2015) the trust scored 100 for cleanliness which was above the England average of 98.
- There was access to hand gel in all clinical areas.
- The trust was proactive in monitoring the use of antibiotics and there were specialist pharmacists who supported clinicians directly on the wards and performed regular audits.

Summary of findings

- Trust figures showed C.difficile infection rates were lower than expected which is a useful indicator of appropriate antibiotic stewardship.
- The Director of Infection Prevention and Control chaired the infection control committee which reported to the healthcare governance committee, a board sub-committees and the trust executive group.
- There was a team of infection control nurses, with administrative support. An IT system was in place to support infection prevention and control. In addition, there were 4.8wte staff in the surveillance team.
- Members of the infection prevention and control team felt that they had a strong clinical profile at the trust and there was board to ward commitment to infection prevention and control.

Assessing and responding to patient risk

- The trust used a local adaptation of a national early warning tool called Sheffield Early Warning Score (SHEWS) that indicated and alerted staff to when a patient's condition was deteriorating. This was in use across the acute services. In medicine we saw that audit of SHEWS was undertaken on a monthly basis. There were clear processes for escalation of the deteriorating patients across most of the acute core services.
- We saw following a review of records that risk assessments were undertaken including falls, moving and handling, nutrition, tissue viability and venous-thromboembolism (VTE) assessments. In surgery we reviewed 36 records at the Northern General Hospital we saw that 21 of the risk assessments were incomplete, in other acute services we saw that risk assessments were completed.
- In the Emergency department at the Northern General Hospital there was a triaging system for patients arriving by ambulance that included patients arriving initially into an area known as the 'pit stop'. This area provided rapid assessment and initial treatment and was staffed by an Emergency Care Consultant. Patient's vital signs were not always obtained in this area.
- We raised concerns regarding the assessment and response to patient risk in the A&E at the Northern General Hospital. The College of Emergency Medicine (CEM) guidance states a face-to-face assessment of patients should be carried out by a clinician within 15 minutes. During the inspection we saw that patients waited on average 30 minutes for triage with a maximum recorded wait of 135 minutes.
- During the inspection we raised concerns regarding the clinical decision unit (CDU); the area included a bedded area and a separate seating area. Although there was criteria for the

Summary of findings

referral of patients to the CDU we had concerns regarding the care of patients, escalation of patients who may deteriorate whilst in the seated area and staffing of this area. During the inspection we saw a patient who had deteriorated whilst waiting in the CDU seated area; this was raised with staff who took appropriate action however the patient was not moved from the area.

- Staffing of the seated area was overseen by a registered nurse on the CDU and the observation of patients was through an opening in the wall separating the bedded area from the seating area. We raised concerns regarding the current staffing of the unit.
- The CDU was also used as a quiet area for patients presenting with mental health conditions; the inspection team had concerns regarding the environment due to the presence of ligature risks in two of the side rooms and the toilet and the lack of visibility.
- Most surgical wards had medical patients (outliers); we were told by staff on five wards that there were no set procedures for medical staff to review these patients at the Northern General Hospital. However, trust managers told us that the patients were under the care of a nominated physician who reviewed them as part of their ward round. At the Royal Hallamshire Hospital there was a Consultant Physician who had responsibility for reviewing any medical patients who were being cared for on surgical wards.
- There were concerns in critical care regarding the emergency tracheostomy management on Osborn one and three. Staff did not have access to an emergency tracheostomy algorithm nor was there a standardised approach to escalating the deteriorating patient with a tracheostomy in the event of a blockage. There was no way of knowing which tracheal tube a patient had in place on Osborn one. The 2014 Intensive Care Society standards state a sign should be placed above the patient's bed. We escalated our concerns and these were addressed by the trust by the end of the inspection, including the addition of emergency tracheostomy boxes on resuscitation trolleys.
- The World Health Organisation (WHO) surgical safety checklist was in use, this is a core set of safety checks to improve safety during surgery. We observed the checklist being used appropriately across all surgical services. We saw evidence of audit of the checklist being carried out, 28 spot check audits across the two main hospital sites had been carried out up to 30 November 2015 which showed compliance rates of 61% to 100%.

Summary of findings

Mandatory Training

- The trust had a comprehensive package of mandatory training through a variety of mediums including face-to-face and e-learning modules. We were concerned that mandatory training was not given sufficient priority across the trust due to the mandatory training rates not meeting the trust target in many of the core services. However, we were told that the Chief Executive led summits on the issue and the performance of the directorates was picked up at directorate reviews.
- Mandatory training rates were variable across the trust. There was a trust target of 90% however we saw rates varied depending on the type of mandatory training with many of the services not achieving the trust target. For example in surgery compliance was reported as 83%, in medicine medical staff groups were not compliant with the trust target with areas reporting to have achieved the quarter one target of 70% by the end of the second quarter.
- In community services mandatory training rates for community nursing were 64% overall.
- At the Charles Clifford Hospital paediatric resuscitation basic life support training was 34%
- Access to mandatory training had been improved through the provision of computers in staff rest areas to facilitate access to e-learning packages. Staff in many of the services told us they had protected time for mandatory training however there were areas where staffing shortages had impacted on ability to attend mandatory training for example in medicine at the Royal Hallamshire gastroenterology and stroke and geriatric medicine compliance was poor for infection control training, basic life support and moving and handling

Records

- The trust had a combination of paper based and electronic records. Care planning was based upon a system of nursing care guidelines that were evidence based and there was a process in place to ensure that these were reviewed on a regular basis and were evidence based and referenced.
- In medicine, however, there were concerns regarding the care planning process. There were evidence based nursing care guidelines, which fulfilled the function of care plans, available for reference for a wide range of possible care needs. However, these were not printed and available at the patients' bedside or with the patients' care record. Some wards had printed reference files available for staff to use, however we did not observe staff using these. Other wards referred us to the intranet to view these guidelines and again we did not observe

Summary of findings

staff referring to these. Staff told us computers were not always easily accessible and that new, bank and agency staff did not always have an individual log on. This meant that care plans and guidelines were not always accessible for staff delivering care. We did observe that planned care was included in the verbal handover in medicine.

- In surgery records were not always stored securely. The inspection team reviewed 40 sets of records across the two hospital sites, overall the content was accurate and in line with the Nursing and Midwifery Council guidance however none met the requirements of the General Medical Council (GMC) guidance on keeping records.
- In other core services and in community services we saw that records were overall complete and maintained.

Are services at this trust effective?

We rated effective as good because:

- There were systems in place to ensure that staff had access to relevant evidence-based policies and guidelines.
- The trust had participated in a range of national and local audits. Patient outcome measures showed the trust performed mostly within the national averages when compared with other hospitals.
- The trust has developed and implemented an electronic clinical assurance toolkit (eCAT) which enabled wards and departments to monitor standards of care and outcomes for patients. Action plans were in place for any areas requiring action.
- We found many examples of multi-disciplinary working and coordinated care pathways.
- Staff had a clear understanding of consent, mental capacity and deprivation of liberty safeguards.

However, we also found:

- The guidance for staff caring for people at the end of life had been introduced recently and not all staff were clear how they should incorporate this into their clinical practice.

Evidence based care and treatment

- Policies and guidance were available to staff on the trust's intranet.
- Staff were aware of relevant policies and guidelines and showed us how they would access them on the trust intranet.

Good



Summary of findings

- Policies and guidelines were based on relevant and current evidence base and best practice from appropriate professional bodies, including National Institute of Health and Clinical Excellence (NICE), Royal College of Surgeons (RCS), Royal College of Physicians, Association of Anaesthetists of Great Britain and Ireland (AAGBI) and the British Association of Day Surgery Guidance.
- There was an evidence based council established at the trust which reviewed clinical evidence to update practice guidelines.
- There was a process for reviewing and implementing NICE guidance.
- There were tools available to support staff implement evidence-based care such as the hydration and nutrition assurance toolkit (HANAT). Staff followed the enhanced recovery programme (NHS Institute for Innovation and Improvement) in many specialities.
- The guidance for staff caring for people at the end of life had been introduced recently and not all staff were clear how they should incorporate this into their clinical practice.

Patient outcomes

- The 12-month rolling Hospital Standardised Mortality Ratio (HSMR) for 1 June 2014 to 31 May 2015 was 98 (94-102) for all admissions and 'as expected' when compared with hospital trusts nationally. The HSMR for non-elective admissions was 99 (95-103) and elective admissions was 86 (66 - 110).
- The most recent 12-month rolling Standardised Hospital Mortality Index for 1 January 2014 to 31 December 2014 was 0.92 (0.91 - 1.10) with an expected number of deaths of 3414 versus an observed 3410. This was 'as expected' when compared with hospital trusts.
- There were no active Care Quality Commission mortality outliers for this trust at the time of inspection. However, following the inspection, the maternity service was identified as an outlier for puerperal sepsis. The trust reviewed case notes and responded appropriately; an action plan was put in place.
- The Sentinel Stroke National Audit Programme (SSNAP) is a programme of work that aims to improve the quality of stroke care by auditing stroke services against evidence based standards. The trust scored 'D' overall in the SSNAP audit for 2014. The scale is A to E with A being the best rating. Local reports regarding the SSNAP results showed a clear understanding of issues affecting patient outcomes and plans to improve future patient outcomes and audit results.

Summary of findings

- In the National Diabetes Audit 2013, RHH performed better than the England median in 15 indicators and worse than the England median in four indicators. NGH performed better than the England median in 13 indicators and worse than the England median in the other eight. The areas highlighted for improvement were, visit by a specialist team, foot risk assessment and seen by the multidisciplinary team in 24 hours, meal choice and staff awareness.
- The MINAP audit 2014 showed there was an increase from 2013 in the number of NSTEMI patients seen by a cardiologist, admitted to a cardiac ward, and referred for or had angiography. However, the percentages had decreased from 98.9% to 93.5%, 71.8% to 60.7% and 66.5% to 63.3% for the respective indicators. In 2014, the number of patients seen by a cardiologist was slightly lower than the England average of 94.3%. Patients admitted to a cardiac ward was above the England average of 55.6% and patients referred for or had angiography was lower than the England average of 77.9%.
- At a trust level, the standardised relative risk of readmission in elective admissions was higher than the England average. The top three specialties with the highest count of activity were clinical oncology, medical oncology and clinical haematology and they all had a rate around one third higher than the England average.
- NGH had a lower rate of elective readmissions than the England average for gastroenterology and higher readmission rates for cardiology and nephrology.
- The trust's standardised relative risk of readmission for all non-elective admissions is in line with the national average. However, NGH had a higher readmission rate overall for non-elective readmissions and for respiratory and geriatric medicine. NGH had a lower readmission rate for general medicine.
- The trust had higher than the England average standardised relative readmission rates (2014) for elective surgical patients for trauma and orthopaedics, colorectal and hepatobiliary and pancreatic surgery.
- The trust had higher than the England average standardised relative readmission rates (2014) for non-elective surgical patients for trauma and orthopaedics, colorectal and general surgery.
- The National Bowel Cancer Audit (2014) showed mixed results. The trust scored better than England average for multi-disciplinary team discussion, clinical nurse specialist involvement and scans undertaken. However, the trust

Summary of findings

attempted laparoscopic surgery in 35.7% of patients (lower than the England average of 54.8%) and 76.8.8 % of patients undergoing major surgery stayed in the trust for an average of more than five days (worse than the England average of 69.1%).

- The Lung Cancer Audit (2014) results showed the percentage of patients receiving surgery was similar to the England average. The audit showed better results than the England average for multi-disciplinary team discussion and for scans undertaken before bronchoscopy.
- The trust participated in the National Hip Fracture Audit. Findings from the 2014 report showed the hospital was better than the national average in five out of seven areas. Examples were patients admitted to an orthopaedic ward within four hours, surgery on the day of or the day after admission and preoperative assessment by a geriatrician. The hospital was worse than the national average in patients developing pressure ulcers and the total length of stay. The trust had set up a multi professional fractured neck of femur group to review length of stay and mortality.
- We found the National Emergency Laparotomy Organisational Audit 2014 showed 13 out of 28 measures (46%) were not available. For the 2015 patient audit results, the trust scored green (70-100%) for the standard “arrival in theatre in timescale appropriate to urgency”. The trust scored amber/red (below 69%) for the other 10 standards, which included “preoperative review by consultant surgeon and anaesthetist” and “consultant surgeon and anaesthetist present in theatre.” The trust submitted the report to the clinical effectiveness committee following the audit. An action plan was developed that included relaunching the pathway for emergency laparotomy patients across the trust and reviewing the daily input from elderly medicine.
- The trust underwent an Anaesthesia Clinical Services Accreditation review in 2015. This review assessed performance against 95 standards. The review concluded satisfactory evidence had been supplied to meet 89 of the standards. We saw evidence that the trust was working towards the recommendations of the review to meet the remaining six standards. The unmet standards included administration support, trust support for audit and research and evidence of training in the use of equipment. The trust was subsequently awarded accreditation.
- The trust’s overall performance record for Patient Reported Outcomes Measures (PROMs) for hip and knee replacements

Summary of findings

and varicose vein surgery is in line with the national average. A PROM for groin hernia procedures (EQ-5D Index) had seen smaller improvements and worse results than the national average.

- Overall, the trust completed 52% of procedures as day cases. NGH had a day case rate of 37%.
- The trust participated in Hip Attack, which was an international research trial of patients with a hip fracture that required surgical intervention.
- The results from the latest ICNARC data available to us at the time of our inspection was for October 2014 – March 2015, showed patient mortality rates for GICU within the expected ranges when compared with similar units nationally and these had remained stable.
- All of the pathology laboratories were accredited with Clinical Pathology Accreditation (CPA). The pathology services were awaiting confirmation of a date for inspection by the United Kingdom Accreditation Service. There were no significant outstanding issues from the most recent CPA inspection.
- The trust has developed and implemented an electronic clinical assurance toolkit (eCAT) which enabled wards and departments to monitor standards of care and outcomes for patients. The tool was used annually in each area and reviewed by the governance team. Action plans were in place for any areas requiring action.

Multidisciplinary working

- Staff told us there was good teamwork and communication within the multidisciplinary teams.
- We found many examples of multi-disciplinary working and coordinated care pathways. For example, the Active Recovery Team and PhysioWorks were both excellent examples of multi-professional teams working closely together for the benefit of patients. We also attended a multi-disciplinary meeting on the neonatal unit during our inspection. The meeting was well attended by a range of professionals, including the neonatal outreach team and link staff to community services.
- The trust utilised a microsystems improvement methodology which involved the multidisciplinary team working together on improvements.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Most staff had a clear understanding of consent, mental capacity and deprivation of liberty safeguards.

Summary of findings

- The trust had a Mental Capacity Act Facilitator who was responsible for supporting staff with Mental Capacity Act and Deprivation of Liberty concerns.
- The trust's DoLS policy was overdue for review from October 2013.
- We were concerned that Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) were not always made in line with national guidance. During the inspection we looked at 43 DNACPR forms across the hospital sites and four DNACPR forms in community. The forms in community were completed appropriately and there were no concerns. Across the hospital sites however there was variation in the quality and completeness of the forms for example delays in forms being countersigned, in six of the forms at Northern General Hospital discussions had not taken place with the family where the patient did not have capacity.
- We spoke with the Medical Director about DNACPR forms and they informed us that they were aware of the issues regarding completion of the forms and the lack of documentation of mental capacity. Action was being taken to address this.
- The trust had undertaken an audit in February 2015 on the McMillan Palliative Care Unit to assess the accuracy of form completion, results were variable for example 100% of forms had the patient name but only 65% had the name of the next of kin. The timescales for forms being countersigned by a consultant ranged from one to 28 days. Where DNACPR was not discussed with the patient 60% were discussed with a family member but 40% were not. There were 14 recommendations from the audit.

Are services at this trust caring?

We rated caring as good because:

- Feedback from patients and relatives was positive about the care they received.
- There were a number of initiatives to provide emotional support such as a bereavement support group held in the community each quarter and bereavement support provided by teams of nurses and midwives within maternity services.
- We saw numerous examples of compassionate care being provided throughout the inspection.

Compassionate care

Good



Summary of findings

- The Cancer Patient Experience Survey 2013/14 showed the trust was in the top 20% for two indicators, the bottom 20% for one indicator and in the middle 60% of trusts for the remaining 30 indicators.
- The Patient-led assessments of the Care Environment (PLACE) for 2015 scored the trust above the England average for privacy, dignity and wellbeing.
- The trust scored about the same as other trusts for all indicators except one which was better, in the Accident and Emergency survey (2014).
- The inpatient Friends and Family Test results showed the percentage of patients who would recommend the trust was around the national average at 96%.
- Friends and Family Test results were generally above the England average for antenatal care, birth, postnatal ward and postnatal community care between March 2014 and February 2015. Ninety eight percent of responses stated women would be 'likely' or 'extremely likely' to recommend the unit. The local inpatient survey dashboard asked women about their care at the hospital. The trust scored above the expected average in most areas.
- In the CQC maternity care survey 2015, the hospital performed the same as other trusts around the kindness and understanding by staff after the birth of their baby.
- We saw numerous examples of compassionate care being provided throughout the inspection.

Understanding and involvement of patients and those close to them

- The CQC maternity survey 2015 demonstrated that the trust scored similar to other trusts in women and partner involvement in care.
- The trust scored about the same as other trusts in the Accident and Emergency survey (2014) for patients being involved as much as they wanted to be in decisions about their care and treatment.
- The trust scored about the same as other trusts in the inpatient survey (2015) for being involved as much as they wanted to be in decisions about their care and treatment and for being given enough information on their condition and treatment.

Emotional support

- The trust scored better when compared to other trusts in the Accident and Emergency survey (2014) for feeling they had enough time to discuss their health or medical problem with a doctor or nurse.

Summary of findings

- Specialist midwives were available to provide additional support for women in the form of a Birth Options clinic. This gave women the opportunity to discuss their fears and concerns and plan their care.
- Mental health guidelines and a care pathway existed for the care of women who had mental health disorders, including previous puerperal psychosis. Mental health screening was undertaken during pregnancy.
- Confidential professional counselling from a qualified therapist registered with the British Association of Counselling and Psychotherapy was available for women using the termination of pregnancy services. Consultations were available before and after procedures.
- Multi faith chaplaincy support was available 24 hours a day. We saw chaplaincy leaflets which indicated there was emotional and spiritual support for patients and families.
- The trust had a psychology service and staff could refer patients, for example from Weston Park Hospital. We were told this helped patients cope with emotional difficulties.
- There were a number of initiatives to provide emotional support such as a bereavement support group held in the community each quarter and bereavement support provided by teams of nurses and midwives within maternity services.

Are services at this trust responsive?

We rated responsive as good because:

- The trust worked with local service commissioners, including local authorities, GP's, and other providers to co-ordinate and integrate care pathways.
- There were systems in place to support the needs of individuals, including patients with learning disabilities and those living with dementia.
- Referral to Treatment (RTT) within 18 weeks for non-admitted patients and those on incomplete pathways had been performing above the national average since September 2014.
- There was a single point of access (SPA) service who managed referrals from patients and health professionals into all community health services. Effective systems were in place to direct patients to the right professional at the right time at a venue of their choice.
- There was an active recovery team who had redesigned the traditional model of assessing to discharge to the more patient centred approach of discharge to assess. This had resulted in a significant reduction in hospitalisation of over 15,000 bed days.

Good



Summary of findings

- The trust reviewed monthly complaints and feedback. We found evidence that themes were shared and learning had taken place.

However, we also found:

- In the reporting period September 2014 to September 2015, the emergency department at Northern General Hospital was meeting the four hour target to discharge or decision to admit an average of 90.3% occasions. This was below the 95% national standard.
- Since July 2013, the trust's RTT performance for patients admitted to hospital had mostly been below the trust's 90% standard.

Service planning and delivery to meet the needs of local people

- The trust provided acute and community services. Community services became part of the trust in 2011. There has been integration of the community services and they are part of a combined directorate with geriatric and stroke medicine. We saw good examples of community services working closely and planning services with the acute hospitals to provide integrated care to patients. For example, the community stroke service formed an integral part of the stroke pathway.
- Staff told us they worked with local service commissioners, including local authorities, GP's, and other providers to co-ordinate and integrate care pathways. There were arrangements in place to facilitate patients who required support from mental health services or local authority social services.
- Care groups developed capacity and demand plans annually that fed into the trust capacity and demand plans for the year.
- Due to the increase in attendances at the Emergency Department, a review of the emergency department pathways into the trust had been undertaken. Changes to service delivery were being implemented to enable the service to meet the needs of people.
- Clinical directorates had individual five year strategies that were linked to trust's strategy, aims and objectives.
- The trust had approved a 5 year investment programme in technology to transform care delivery within the hospitals and people's own homes and communities. This was in the process of being implemented. This was planned to enable the organisation to support the work underway to develop integrated care teams and new models of care.

Meeting people's individual needs

Summary of findings

- An alert was available on the computer based administration system to identify patients with learning disabilities. The Sheffield Case Register database was downloaded into the trust patient administration system; this identified patients with a learning disability.
- Nursing staff were aware of and used the learning disability passport.
- There was an identified nurse director to lead on the care of patients with learning disabilities. There was no dedicated specialist nurse. Matrons were notified of relevant admissions through the use of the learning disability passport.
- The trust had undertaken an adult inpatient survey for patients with learning disabilities with an external agency and was awaiting the report.
- We saw examples of how patients with learning disabilities were supported. For example, staff in theatre had introduced a learning disability pathway. An operating list was dedicated to patients with a learning disability, so if the patient needed more than one procedure this was carried out on the same operating list under the same general anaesthetic.
- Within the community dental services there were several outstanding examples of services implemented to meet individual needs. These included a communication tool enabling children with autistic spectrum disorders and other communication difficulties to accept dental treatment, a service for residents living in care homes and a dental service offered to Sheffield's homeless community.
- There was an interpreting service to support the communication needs of people who were non-English speakers, people for whom English is a second language, and people who are deaf, in order to ensure that they have appropriate and equitable access to hospital services.
- An external supplier was contracted to provide telephone, face to face and British Sign Language interpreting. During 2014/15, 66% of the spoken language interpreter services were provided by telephone and 34% were face to face.
- The trust had a range of approximately 1500 patient information leaflets. There was a process to request these in alternative languages or formats.
- Patients who are registered blind or deaf had an electronic flag on the patient administration system to alert staff.

Dementia

Summary of findings

- The trust had a clinical lead and nurse practitioner for dementia care. They also had dementia link nurses who attended regular meetings and updated their teams on any pertinent issues.
- An electronic flagging system for people with dementia was being developed with the introduction of the new electronic patient record. An alert was available on the new computer based administration system to identify patients diagnosed as living with dementia in the emergency department.
- There was a process in place to notify the dementia nurse practitioner of relevant admissions.
- The trust had a dementia training needs analysis and strategy. Training on dementia was included in the trust induction. Nursing staff were also encouraged to complete an e-learning module 'care of patients living with dementia'. Staff who had completed this said they had found it useful.
- Nursing staff also told us about the 'this is me' document, which they encouraged patients and relatives to bring into hospital during their stay. 'This is me' is a simple and practical tool people living with dementia can use to tell staff about their needs, preferences, likes, dislikes and interests.
- A memory box had been developed within the CDU. This box contained papers, activities and photographs to be used with patients living with dementia. A yellow patient wristband was used to highlight patients living with dementia to help staff provide appropriate care.
- The trust had achieved the 2014/15 CQUIN with more than 90% of patients over 75 screened for dementia.
- A ward at the Northern General Hospital had been developed to meet the needs of patients living with dementia. A site overview assessment of RHH using PLACE criteria (2015) showed that improvements were needed on some wards with regard to being "dementia friendly". Common issues related to signage, flooring, lack of contrast colour for toilet doorways and seats.

Access and flow

- In the reporting period September 2014 to September 2015, the emergency departments at the trust were meeting the four hour target from attendance to discharge or decision to admit an average of 90.3% occasions. Data ranged from 74.8% in December 2014 to 97.5% in August 2015. Due to the implementation of a national computer patient administration programme the department was unable to provide any data, or confirm accuracy of data to report on performance activity in the emergency department following the introduction of the system on the 28 September 2015.

Summary of findings

- The percentage of emergency patients waiting between four and 12 hours from the decision to admit to admission had been in line with the England average from April 2014 to July 2015.
- The trust's target was that 90 per cent of admitted patients should start consultant-led treatment within 18 weeks of referral. Since July 2013, the trust's RTT performance for patients admitted to hospital had mostly been below the 90% standard. Data reviewed for May 2015 showed general surgery, trauma and orthopaedics and cardiothoracic surgery did not meet the standard. Thoracic medicine and plastic surgery met the standard. However, the trust overall performed better than the England average during this period. The trust's target was that 95 percent of patients should start consultant-led treatment within 18 weeks of referral. The national standard is that 92 percent of patients on incomplete pathways should not have been waiting longer than 18 weeks since referral. Referral to Treatment (RTT) within 18 weeks for non-admitted patients and those on incomplete pathways had been performing above the national average since September 2014. Cardiology was not meeting the 18-week performance target of 92% (target). The trust recognised this issue and there was a plan for dealing with it. There was a trust level weekly meeting with cardiology.
- An outlier policy was in place. In August 2015, there were 207 outliers (patients who were not cared for on their speciality ward). There was one consultant employed to care for medical outliers across the Royal Hallamshire Hospital.
- There was a patient flow team to support bed management across the trust. Bed management meetings were held three times a day.
- There was also a daily community operational meeting for the combined community and acute care group. This involved staff from across the care group and demonstrated good liaison between the services to assist with patient flow.
- For community services, there was a single point of access (SPA) service who managed referrals from patients and health professionals into all community health services. It was available 365 days a year, from 8 am to 8pm. Outside of these hours the calls were answered by the GP Collaborative. The service used a call routing system to direct patients to the right professional from the start. The team had extensive local knowledge and specialist expertise and were able to access to up to date information on service capacity. This meant that they could give advice on which service would be most appropriate for the patient. Once referred to a service, confirmation was sent to referrers to ensure they were kept

Summary of findings

informed of who was caring for their patients. The aims of the service were to ensure patients were seen by the right professional at the right time at a venue of their choice. We thought this service was outstanding.

- There was an active recovery service in the community which could see a patient within two hours of receiving the referral and was available from 8am - 2am, seven days a week. The team had redesigned the traditional model of assessing to discharge to the more patient centred approach of discharge to assess. The first ward to implement discharge to assess had a sustained reduction in length of stay of 7 days. The service had provided support for over 6300 patients transferring from hospital back to home over the previous 12 months. We saw evidence that showed on average, a 2.4 day reduction in delay across the hospital-community interface, which represented a reduction in hospitalisation of over 15,000 bed days.
- Some of the medical wards were involved in a 'ready to go' service improvement project which was investigating discharge delays.

Learning from complaints and concerns

- The trust had an up to date concerns and complaints policy in place. Complainants are contacted in the first two days following receipt of the response and we corroborated this through a review of a sample of complaints. All complaints are signed off by the Chief Executive.
- Over 90% of complaints were responded to within 25 working days from July to September 2015 following improvements in the process.
- The trust reviewed monthly complaints and feedback dashboard reports at the Patient Experience Committee. These reports gave an overview of key performance indicators including numbers of complaints received/closed, response times, themes and exception reporting based on all complaints data. They were also discussed at the monthly meetings of the Healthcare Governance Committee, which is a sub-committee of the Board of Directors.
- Complaints were discussed to share findings and identify learning outcomes at departmental and governance meetings. Real examples of complaints were used as part of training to ensure learning.
- Changes made as a result of complaints were reported in the quarterly complaints and feedback reports. Examples of changes following complaints included the development of new guidelines for staff and changes to referral pathways.

Summary of findings

- We reviewed a sample of 10 complaints and found them to be in line with the trusts own policy however seven of the complaints the inspection team felt lacked apology and there was use of clinical terminology that may not be fully understood. There was also limited identification of recommendations
- The trust monitors their complaints processes through audit of 50 complaints and interviews with complainants. We were told that following a recent audit actions from complaints were not always implemented. We were given an example of food on a specific ward, governors were asked to look at the issue and found that food was being given out differently on the ward where concerns had been raised.

Are services at this trust well-led?

We rated well-led as good because:

- The trust had a clear vision and corporate strategy which was known and understood by staff. This was supported by the directorate strategies.
- The trust's values were clearly embedded across the organisation. Staff consistently spoke about the PROUD values.
- There was an effective governance and performance framework that was in place from ward to board that allowed assurance to be gained at board level.
- There was stable trust board in place. The Chief Executive had been in post for 14 years. There was effective leadership throughout most of the organisation.
- There was a strong focus on continuous learning and innovation and improvement was evident throughout all levels of the organisation. Staff were engaged in the quality and service improvement agenda.
- We identified some innovative patient experience engagement activity, such as the use of art therapy, pet therapy and a 'listening wall' for patients to say what they would like to improve the clinical environment.
- The trust had a number of initiatives that had been nationally recognised as good practice.

However:

- We were concerned regarding the lack of local end of life care strategy.
- The NHS staff survey (2015) found the trust's engagement score of 3.74 was below (worse than) average when compared with trusts of a similar type.

Good



Summary of findings

- There was some concern that learning from incidents although well-established within directorates it was not evident on wider care group basis.

Vision and strategy

- The trust had a clear vision and corporate strategy which was implemented in 2012 and was due for review in 2017.
- A set of values, were part of the strategy. These were known as PROUD values which was an acronym for Patient first, Respectful, Ownership, Unity and Deliver. We found that these values were clearly embedded across the organisation. The values were used within recruitment processes and appraisals. Staff consistently spoke about the PROUD values and reported these made appraisals more meaningful.
- The trust had an overarching corporate strategy called 'Making a Difference' which covered the period 2012 to 2017. This was refreshed in 2015 to ensure that the strategic direction of the trust was still fit for purpose and remained focussed on the delivery of high quality care. The corporate strategy was underpinned by a number of specific strategies. Five aims were set out in the strategy that informed organisational objectives, development of directorate business plans and supported individual development plans. These focussed on clinical outcomes, delivery of patient centred care, workforce, financial stability and research and innovation.
- The trust's quality strategy had clearly identified goals and actions.
- Clinical directorates had individual five year strategies that were linked to trust's strategy, aims and objectives. The directorate strategies had consideration of the other clinical departments they worked with to deliver high quality care and the assistance required from corporate directorates and other partners.
- There was a transformation through technology programme in the process of being implemented with a vision to provide quality healthcare enabled by technology.

Governance, risk management and quality measurement

- There was a Board Assurance Framework and corporate risk register that identified both strategic and operational risks. We reviewed the corporate risk register which documented actual risk, control measures and residual risk ratings. The Board Assurance Framework was reviewed by the board on an annual basis and was in line with the trust's annual report and quality

Summary of findings

accounts. We reviewed the Board Assurance Framework and found it reflected the strategic risks, identified executive leads, controls identified for mitigating risks and the assurance of mitigation of risk.

- The trust had an effective governance system in place supported at board level by a number of assurance committees. The key assurance committees included the Healthcare Governance committee, Audit Committee and Finance, Performance and Workforce committee.
- The Healthcare Governance committee was held on a monthly basis and reported directly to the board. The committee was chaired by a non-executive director. There was a Healthcare Governance Arrangements policy in place that set out the governance framework and the committee had terms of reference that we reviewed during the inspection.
- We reviewed the Complaints, Incidents, Concerns, Claims and Inquest report for the Healthcare Governance meeting for June 2015 and the Health & Safety Report for 2014 to 2015 and plan for 2015 to 2016. Reports were linked to the trust strategic aims.
- The trust had a well-established governance framework that supported delivery of safe and high quality care from 'ward to board'. At a service level, across both acute and community services, there were processes in place for teams to review incidents and ensure learning was shared. Across the care groups and at directorate level there were monthly governance meetings. The framework was supported by governance leads in each of the directorates. There was some concern that learning from incidents, although well-established within directorates, was not evident on wider care group basis.
- There was a Safety and Risk Management Board that was a sub-committee of the healthcare Governance Committee. Directorate governance leads attended and risk scores were reviewed at this meeting.
- Governance leads had clearly defined roles and responsibilities at directorate level.
- The trust had a Risk Management Policy. Risk registers were held at directorate and care group level and there was a clear process for escalation of risk. Risks were categorised using a risk matrix and framework based upon the likelihood of the risk occurring and the severity of impact. Risk registers were up to date and reviewed by the directorates and staff were aware of how to escalate risks up through the governance structures. However, in the Emergency department at the Northern General Hospital, the risk register did not include some of the issues found on inspection or show when the risks were last reviewed.

Summary of findings

- Staff we spoke with across the core services were able to articulate their operational risks and were taking actions to mitigate risks.
- There was a performance and accountability framework in place both within care groups with directorates being held to account and up to board level through the Director of strategy and operations. Directorates met with the Trust Executive Group to review business plans and risks twice a year. There were integrated performance reports.
- The trust had an internal and external audit programme and a clinical audit programme set for 2015 – 2016. Clinical audit priorities were based on national requirements followed by trust, directorate then consultant led priorities. Internal audit projects have an executive and operational lead identified.
- Nurse staffing levels were reviewed in line with the National Quality Board guidance 2013. We reviewed a six monthly staffing review report to the Board.
- There was a ward accreditation programme in place called 'eCAT' which was a clinical assurance toolkit that included safety thermometer data, incidents and infection control data.
- An external Annual Quality Governance Assessment against the Monitor Framework had been carried out in September 2015. This report identified many elements of good practice with a focus on patient quality and safety.
- The trust was forecasting an £11million deficit at the time of the inspection with a cost improvement programme of £25million. The cost improvement programme was based upon the trust wide approach to improvement and was devolved to care groups and their directorates.
- Cost improvement programmes and business cases were reviewed for impact on quality and we were provided with examples of cases that had been declined due potential negative impact on quality.
- There was medical examiner at the hospital. They were in post to consider themes and risk management around cause of death.
- The trust participated in the Sign up to Safety Campaign.
- The trust had previously had concerns raised in a small number of services. These included concerns regarding clinical care and bullying and harassment. The information we received was taken into account by the teams inspecting the relevant core services. We did not find any evidence of bullying and harassment during the inspection.

Summary of findings

- Where issues had been identified, we saw they had been investigated. This included the trust commissioning external independent reviews in response. Some reviews had taken longer than expected and this meant findings and actions were not always implemented in a timely manner.
- We looked at the commissioned external reviews in cardiac surgery, plastic surgery and audio vestibular medicine and noted that there were no substantial clinical concerns identified. We were satisfied that the trust had undertaken external reviews and we will continue to monitor them against their action plans.

Leadership of the trust

- There was stable trust board in place. The Chief Executive had been in post for 14 years and was well-respected across the organisation. The mostly recently appointed board member was the medical director who had been in post for over 3 years. The external governance review identified the board as being unitary, well-functioning with a focus on operational performance along with effective strategic discussion.
- The leadership of the board by the Chairman was noted in the external governance review to be impressive. Additionally the contribution of the Chief Executive was also described as impressive.
- We raised some concerns regarding the size of the portfolio for the Medical Director, however there were plans in place to address and reduce this in the near future. In addition there were plans to expand the number of executive directors to strengthen the board and support the strategic agenda.
- The trust was led through nine care groups. Each care group was led by clinical directors in conjunction with a nurse director and operations director. The levels of clinical engagement and leadership across both acute and community settings were exceptional and there was a strong clinical leadership model in place.
- We found examples of effective leadership throughout the organisation. Each of the care groups were led by a triumvirate of Clinical Director, Nurse Director and Operations Director. The clinical directors are appointed by the Chief Executive for a period of three years
- Leadership programmes were in place for varying levels of staff across the trust and leadership development formed part of the trust Organisational Strategy.

Summary of findings

- There was a clinical management board which brought together the clinical directors and other senior leaders and had a role of providing advice to the Board of Directors and the trust executive group
- There was a leadership forum which was chaired by the Chief Executive and met twice a year with a focus on transformation of services, leadership and development.
- All Nurse Directors and the Chief Nurse carried out clinical shifts on wards every month.
- We found 84% of staff had an appraisal including medical staff.
- At the time of inspection, the average staff sickness rate was reported as 4.4% against a trust target of 4%.
- Staff spoke positively about the leadership at the trust. They told us that senior leaders were visible; they were very positive about the Chief Executive and it was evident that he visited areas of the trust regularly. Staff told us about regular email communication they received from the Chief Executive.
- The NHS staff survey (2015) found the percentage of staff that got support from their immediate managers was worse than the national average.
- The National Training Scheme Survey from the General Medical Council 2015 assessed the trust as performing as expected in 12 of the 13 indicators and worse than expected for inductions.

Culture within the trust

- A culture of innovation and improvement was evident throughout all levels of the organisation.
- Staff spoke positively about the culture, although movement of nursing staff to cover shortfalls had affected morale in some areas.
- The trust had implemented the Sheffield Microsystem Coaching Academy (MCA), supported by the Health Foundation. This was designed to train coaches within the Sheffield healthcare system to help front line teams make improvements and build quality improvement capability. We saw examples of this in practice. The project won a Changing Culture Award in 2014, and the Head of Quality Improvement won the Leadership Academy, Coach of the Year Award.
- Workshops on customer care had been attended by over 1,200 staff and a 5% reduction in complaints about staff attitude had been identified.
- The NHS staff survey (2015) found the percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months was better than the national average.

Summary of findings

- In the dental hospital, many of the staff described the environment as feeling like a family with a general consensus of there being a strong team spirit and sense of belonging to provide a high standard of patient care.

Fit and Proper Persons

- The trust was meeting the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role.
- The trust had a policy and procedure in place for the Fit and Proper Person that was ratified by the Trust Board on 21 October 2015. The policy covered all executive and non-executive directors and all directors who formed part of the Trust Executive Group.
- We reviewed the personnel files of all the executive and non-executive directors and found they were fully compliant with the requirements of the Fit and Proper Persons Requirement. All executive and non-executive directors had a Disclosure and Barring Scheme check including those employed prior to implementation of the FPPR. There was an annual declaration of ongoing compliance and clear procedures and checks for new applicants.

Public engagement

- The trust had a patient partnership department led by the Head of Patient Partnership. We identified some innovative patient experience engagement activity, such as the use of art therapy, pet therapy and a 'listening wall' for patients to say what they would like to improve the clinical environment.
- There was an active council of governors.
- There had been consultation for areas of the hospital being refurbished. For example, staff had talked with groups for people living with dementia to inform development of the dementia ward at Northern General Hospital.
- Refurbishment of the Huntsmann block at Northern General Hospital had also involved a survey of what patients wanted, plans were shared and carers were consulted. Following feedback, a 'changing places' toilet was included in the refurbishment of Hunstman block at the Northern General Hospital. There was also one available at the Royal Hallamshire

Summary of findings

Hospital. These facilities are designed so people with profound and multiple learning disabilities and their carers can access appropriately designed toilet and changing facilities, including hoists. There are 821 designated toilets available nationally.

- There was a monthly patient experience committee, chaired by the Deputy Chief Nurse with representation from each care group. Membership included a representative from the local Healthwatch team and patient governors. The meeting included a patient experience case study.
- The trust had adopted different methods of engaging with patients for the friend and family test. They had introduced an automated telephone call to patient, use of text messages and postcards. The method varied according to the population.
- There was a patient story at the Patient Experience Committee.. Voice recordings and videos were used with patient's consent.
- Wards received a report of patient feedback which included comments and videos. Review of the feedback was included in the annual clinical assurance toolkit.
- The active recovery service had a patient experience group. Feedback from patients was used to improve services.

Staff engagement

- The NHS staff survey (2015) found the trust's score of 3.74 was below (worse than) average when compared with trusts of a similar type.
- Results from the NHS staff survey (2015) showed out of 32 questions, 10 results were similar to other trusts, five were better and 17 were worse than average when compared to other similar trusts.
- The trust had introduced 'Listening into Action'. As part of this, the trust completed a pulse check asking staff 15 questions, for example, 'managers and leaders seek my views about how we can improve our services' and 'communications between senior managers and staff is effective.' The 2015 results were better than the trust's 2014 results and better than the average of healthcare organisations.
- We saw some examples of positive staff engagement. For example, staff in the emergency department had developed a "you said we did" board for staff engagement; we saw examples of changes as a result of this. 'Big Breakfast' and 'Afternoon Tea' events were held in critical care departments for staff to discuss any concerns, ideas and talk with the senior leaders in the directorate and hospital.
- The trust had a workplace health scheme which ran in partnership with external organisations.

Summary of findings

Innovation, improvement and sustainability

- Sheffield Teaching Hospitals NHS Foundation Trust is one of seven hospitals that is part of the 'working together' partnership to share best practice and improve patient care. This became an acute care collaborative vanguard project in November 2015.
- NIHR Devices for Dignity (D4D) Healthcare Technology Co-operative was hosted by the trust. D4D works across multiple NHS, higher education, charity, patient and industry organisations to develop technology solutions to unmet clinical needs.
- The Sheffield Microsystem Coaching Academy (MCA), supported innovation and improvement within the trust. There was an improvement team which staff could be seconded into as improvement facilitators for up to two years. The team supported operational teams to implement improvement projects. This was seen to be innovative and supported the focus on sustainable improvement. Examples of [projects including reduction of outpatient waiting times and do not attend rates for patients with cystic fibrosis. Improvement training for staff is also provided across the trust.
- The trust had a strong research focus and strategic links with external organisations. The trust hosted the National Institute for Health Research, Collaboration for Leadership in Applied Health Research and Care. The trust had a Research, Education and Innovation Committee that reported into the Trust Executive Group and then into the board.
- There were 14 academic directorates at the trust. These were identified as 'flagship' directorates involved in research. There was application and selection process before they were recognised as an academic directorate. There was trust support for staff to undertake clinical research.
- The trust had a number of initiatives that had been nationally recognised as good practice. For example, the active recovery team was an innovative service. It was the first in the England to provide this model of care and had been cited by the Royal College of Physicians as an exemplar of good practice. Another example was the duty floor anaesthetist role in theatre developed in Sheffield which was going to be used by the Royal College of Anaesthetists as a beacon of good practice.

Overview of ratings

Our ratings for Royal Hallamshire Hospital

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

Overview of ratings

Our ratings for Northern General Hospital

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

Our ratings for Weston Park Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
End of life care	Good	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Outstanding	Outstanding	Outstanding	Outstanding
Overall	Requires improvement	Requires improvement	Outstanding	Requires improvement	Good	Requires improvement

Overview of ratings

Our ratings for Charles Clifford Dental Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Dental services	Good	Good	Good	Outstanding	Good	Good
Overall	Good	Good	Good	Outstanding	Good	Good

Our ratings for Community Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good	Good	Good	Outstanding	Outstanding	Outstanding
Community health inpatient services	Requires improvement	Good	Outstanding	Good	Good	Good
Community End of Life Care services	Good	Good	Good	Good	Requires improvement	Good
Community health dental services	Good	Good	Good	Outstanding	Outstanding	Outstanding
Sheffield Dialysis Unit	Good	Good	Good	Good	Good	Good
Overall Community	Good	Good	Good	Outstanding	Good	Good

Our ratings for Sheffield Teaching Hospitals NHS Foundation Trust

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients and Diagnostics.

Outstanding practice and areas for improvement

Outstanding practice

Community dental service

- A collaboration between the Sheffield Community Dental Services, NHS commissioners, Dental Public Health consultants and local general dental practitioners led to the development of the Residential Oral Care Sheffield service for residents living in care homes. This collaboration was cited as good practice by the British Society for Disability and Oral Health. This service now covers 80 out of the 88 residential care homes who participate in the scheme in the city of Sheffield.
- The clinical lead was instrumental in developing a national benchmarking tool used by other community dental services and NHS dental commissioners for describing the complexity of patients treated by community dental services. An evaluation of the outcomes of the pilot project was delivered at the National Association for Dentistry in Health Authorities and Trusts in 2014.
- Collaboration between the Clinical Lead of Sheffield Community Dental Services and the Head of Psychotherapy Services within Sheffield NHS Foundation Trust developed a dental nurse led Pain and Anxiety Service. This led to a reduction in the numbers of patients needing intra-venous sedation for dental treatment and the overall waiting times for intra-venous sedation.
- Sheffield Community Dental Service provided a service for the Sheffield homeless under the auspices of the 'Archer Project at the Cathedral'.
- Sheffield Community Dental Service had developed a communication tool known locally as 'the widget sheets' enabling children with autistic spectrum disorders and other communication difficulties to accept dental treatment. An evaluation of this audit tool was published in the peer reviewed international scientific publication 'Journal for Disability and Oral Health' in 2014.
- The development of a number of nationally recognised clinical benchmarking tools by Sheffield Community Dental Service was a result of exceptional leadership provided by the current Clinical Lead of the Service.

Community Adults

- The active recovery service was a responsive service, which aimed to reduce un-necessary hospital admissions and facilitate the timely discharge of more complex patients from hospital. The team was multidisciplinary and multiagency with health and social care working closely together. The service had redesigned the traditional model of assessing to discharge to the more patient centred approach of discharge to assess resulting in reduced length of stay for patients and improved patient flow within the hospital.
- The Single Point of Access (SPA) service managed referrals from patients and health professionals into all community health services. The service used a call routing system to direct patients to the right professional from the start. The team had extensive local knowledge and specialist expertise and were able to access to up to date information on service capacity. This meant that they could ensure patients were seen by the right professional at the right time at a venue of their choice.
- We thought the person centred care planning was outstanding. The aim of this was to provide support for patients considered to be at high risk of hospital admission at an early stage. Community nurses and GPs worked together to develop patient and carers confidence in managing their own health. The community matron supported this. There were locality champions for person centred care planning in each of the four localities.

Northern General Hospital

- The patient care and experience delivered by staff in the Bev Stokes Day Surgery Unit was outstanding, particularly in relation to patients living with learning disabilities and dementia.
- The duty floor anaesthetist role in theatre developed in Sheffield was going to be used by the Royal College of Anaesthetists as a beacon of good practice.
- The development of a relative's room in the theatre complex.

Outstanding practice and areas for improvement

- On GICU /GHDU there was the use of an electronic patient information system to ensure timely and accurate records, access to trust and local policies, procedures and guidelines. The system ensured effective care was delivered and it was fully integrated and provided real-time information across teams and services.
- An advanced clinical pharmacy service which included a consultant pharmacist and pharmacy prescribers had been developed to improve the safety and efficacy of medicines used in critical care.
- The use of the Enhanced Recovery After Thoracic Surgery (ERAS) programme had resulted in marked improvements in the quality of care for patients on CICU.
- The laboratory team had introduced a 'Patient Safety Zone' project into the inpatient wards and in the community. The aim was to reduce labelling errors. Disturbance or distraction while taking blood samples has been identified as a major risk factor for errors. This initiative had been introduced to improve patient safety. Pathology staff showed us lots of publicity material, including branded biro pens.
- In laboratory medicine, we observed large screens above the bench dealing with urgent samples. It contained a full list of patients waiting for results in the accident and emergency (A&E) department. The same screens were on display in A&E. This meant laboratory staff could see exactly who was waiting in A&E and gave context and 'humanity' to the samples they were analysing. Urgent results for A&E samples were available in one hour because of the use of this management tool.
- Radiology provided an excellent service of 'hot reporting' for reporting x-rays for A&E patients; results were ready within 20 minutes.
- Geriatric medicine had historically been part of acute medicine but was now combined with community services.
- The use of duty floor anaesthetist role in theatre, developed in Sheffield, was going to be used by the Royal College of Anaesthetists as a beacon of good practice.
- Radiology provided an excellent service of 'hot reporting' for reporting x-rays for minor injury patients; results were ready within 20 minutes
- Histopathology was using cross-site digital pathology to speed up processing time for frozen sections.
- On GICU and NICU there was the use of an electronic patient information system to ensure timely and accurate records, access to trust and local policies, procedures and guidelines. The system ensured effective care was delivered and it was fully integrated and provided real-time information across teams and services
- An advanced clinical pharmacy service which included a consultant pharmacist and pharmacy prescribers had been developed to improve the safety and efficacy of medicines used in Critical care.
- The one to one team and specialist midwife clinics gave greater assurance that high risk women continued to have a choice on the care they received in pregnancy.
- The rapid access clinic reduced readmissions of babies with feeding problems.
- The GRIP project responsible for getting research into practice improved services for maternity and gynaecology.
- The termination of pregnancy service gave women continuity of care in an appropriate caring environment. The seven day service gave women choice and improved accessibility.
- The use of the Enhanced Recovery programme in both maternity and gynaecology improved the service for women.

Royal Hallamshire Hospital

- Staff in theatre had introduced a learning disability pathway. An operating list was dedicated to patients with a learning disability, if the patient needed more than one procedure this was carried out on the same operating list under the same general anaesthetic.

Weston Park Hospital

- Specialised cancer services provided a patient-centred holistic approach to patient care where the whole multidisciplinary team worked together to ensure the patient's experience of the service was the best that it could be.
- The teenage cancer unit had a number of innovations which had been paid for out of charitable funds. These included a 'couples retreat' for end of life patients and their partners. They could spend time away from home and explore issues about coming to the end of life.

Outstanding practice and areas for improvement

Community end of life care

- The intensive home nursing service provides support for patients and their families in the last days and hours of life. Relatives consistently praised the service and the staff who provided it.

Community inpatients

- Feedback we received from patients was consistently positive about the way nursing and therapy staff treated them. Patients told us that staff go the extra mile. Staff and patients confirmed that the unit had a flexible approach to care.
- Patients were supported emotionally. Activities such as singing, arts and crafts were arranged to prevent social isolation and boredom.

Charles Clifford Dental Hospital

- An holistic approach to individual patient's requirements was modelled within CCDH, and anxious patients had the option of utilising cognitive behavioural therapy (CBT), acupuncture, hypnosis, inhalation, or intravenous or oral sedation to assist with their dental treatments.
- Staff were sensitive to the needs of vulnerable patients, making reasonable adjustments to ensure that effective two-way communication was achievable to allow patients to be fully empowered to make decisions about their treatment options.
- The service worked with a local dental unit to provide an out of hours (17:00 – 20:00) oral surgery Consultant led clinic for patients who were unable to be released from work within core hours, enabling them to attend one evening each week.

Areas for improvement

Action the trust MUST take to improve

- The trust must ensure patients do not wait longer than the recommended standard for assessment and treatment in the emergency department.
- The trust must ensure that on initial assessment in the "pit stop area" in the emergency department patient's vital signs are taken and recorded consistently.
- The trust must monitor performance information to ensure 95% of patients are admitted, transferred or discharged within four hours of arrival in the emergency department.
- The trust must ensure the safe storage of intravenous fluids.
- The trust must ensure doctors follow policy and best practice guidance in relation to the prescription of oxygen therapy.
- The trust must ensure that guidance is followed in the documentation of foetal heart rate monitoring's.
- The trust must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty at Weston Park Hospital.
- Ensure that guidance is followed in the documentation of foetal heart rate monitoring's. In 86% of 39 CTG records there was no data at the start or

end of the monitoring, such as the women's heart rate, clarification that the clock was correct, staff signature and indication for monitoring. Events in labour and review by a second practitioner were not always documented on the monitoring, in accordance with trust guidance (Intrapartum foetal monitoring - CTG, 5.5, 5.6).

- The trust must ensure divisional risk registers reflect issues in the emergency department and demonstrate evidence of actions and reviews.
- The trust must ensure there is a clear strategy for the end of life care which is implemented and monitored.
- The trust must ensure that staff implement individualised, evidence based care for patients at the end of life.
- The trust must ensure that DNACPR records are fully completed.
- The trust must ensure that, where concerns are raised and investigated, the reviews are undertaken promptly to ensure any necessary actions are implemented in a timely manner.

Please refer to the location reports for details of areas where the trust SHOULD make improvements.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Regulation 12: Safe care and treatment</p> <p>Care and treatment must be provided in a safe way for service users.</p> <p>How it was not being met:</p> <p>Patients waited longer than the recommended standard for assessment and treatment in the emergency department; patient's vital signs were not taken and recorded consistently as part of the initial assessment in the "pit stop area" in the emergency department; 95% of patients were not admitted, transferred or discharged within four hours of arrival in the emergency department.</p>
Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Reg. 12 (1) (g) There must be proper systems in place to ensure the safe management of medications.</p> <p>How it was not being met:</p> <p>Intravenous fluids were not always stored safely and securely, oxygen was not prescribed, drug fridge temperatures were not always accurately monitored or maintained.</p>
Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p>

This section is primarily information for the provider

Requirement notices

Reg.17. Good Governance

Systems or processes must be established and operated effectively to :

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

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

How it was not being met:

In 86% of 39 CTG records there was no data at the start or end of the monitoring, such as the women's heart rate, clarification that the clock was correct, staff signature and indication for monitoring. Events in labour and review by a second practitioner were not always documented on the monitoring, in accordance with trust guidance (Intrapartum foetal monitoring - CTG, 5.5, 5.6).

The risk register for the emergency department did not reflect the identified risks.

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

Some reviews had taken longer than expected and this meant findings and actions were not always implemented in a timely manner.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Reg. 18 (1) There must be sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty.

This section is primarily information for the provider

Requirement notices

How it was not being met:

Nursing staffing levels were below the planned level at Weston Park Hospital with shifts having fewer registered nurses than required on duty.